Supporting Mothers in Alcohol and Drug Recovery Services: Examining Interventions and the Experiences of Staff.

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Foreword

Due to the COVID-19 pandemic the original Major Research Project (MRP) and related Systematic Review (SR) had to be abandoned as recruitment was suspended on 16th March 2020. The University confirmed that projects could be completed with the use of secondary data. The researcher was provided with a number of projects with data available and one was selected. Proposals for the MRP and SR were written and approved by research supervisor and research advisor. It is hoped that this MRP will be part of a larger project into the experiences of both mothers and the staff that support them in drug and alcohol recovery services.

Chapter One

Integrated treatment programmes for Mothers in Addiction Services: A Systematic Review.

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Prepared in accordance with the requirements for submission to Child Abuse & Neglect (Appendix 1.1).

Abstract

Background

Previous research has demonstrated the impact of maternal substance misuse on children (Kelley et al., 2015), and the challenges associated with delivering effective intervention to this population (Greenfield et al., 2007). Parent-child interactions have been shown to be impacted by substance misuse (Pajulo et al., 2001) and interventions have been developed to improve these interactions, in order to target the intergenerational nature of addictions.

Aims

To identify, synthesise and evaluate the effectiveness of interventions which aim to improve parent-child interactions alongside maternal substance misuse.

Method

A search of Web of Science Core Collection, EMBASE, MEDLINE, and PsycINFO, CINAHL, Psychology and Behavioural Sciences Collection, Cochrane, Scopus and PUBMED was carried out on studies published between June 2011 and Jan 2021. Quality rating was carried out by using the Effective Public Health Practice Project Assessment Tool (Thomas et al., 2004).

Results

Seven studies were included in this review. Six reported improvements in parent-child interaction measures; however, there was a great deal of variation in measures used across papers and study quality. A narrative synthesis was used to describe findings.

Conclusion

This review suggests that including a parent-child interaction component is important and appears to be beneficial in this population. However, due to the variation in outcome measures used, this review highlights the need for greater consistency in this area of research and calls for an improvement in quality of research. Implications and recommendations for future research are provided.

Keywords: mothers, substance use, parenting, integrated programmes.

Introduction

Drug and alcohol misuse pose an issue for public health and a risk to individuals and those around them. In the last 20 years, key government policy across the UK and the wider world has addressed the need for a reduction in drug and alcohol use (National Treatment Agency for Substance Misuse; NTA, 2001). Research and government policy have acknowledged that children are particularly vulnerable to the effects of parental substance use (Kelley et al., 2015). For instance, estimates in England show that around 162,000 children live with an opiate-dependent parent and around 200,000 children live with an alcohol-dependent parent (McGovern et al., 2018). A number of studies have demonstrated a link between substance misuse in parents, less effective parenting skills and increased risk of neglect and child abuse (Doud, Lawrence, Goodpasture, & Zeller, 2015; Douglas, 2013; Dubowitz et al., 2011).

Previous reviews have studied parents as a group, but research has highlighted the importance of understanding the unique needs of mothers as distinct from fathers (Agabio & Sinclair, 2019). Studies have shown that more than two thirds of women in substance use programmes are mothers (Brady & Ashley, 2005), and that women are less likely to engage in treatment than men (Greenfield et al., 2007). Research has suggested that this is due to stigma, guilt and shame around parenting and substance misuse (Cox, 2000; Brady and Ashley, 2005), the threat of losing custody of their children (Poole & Isaac, 2001; Kail & Elberth, 2002) and lack of childcare facilities at treatment centres (Greenfield et al, 2007).

Difficult interactional patterns have been found between mothers who use substances and children who have been exposed to substances prenatally (Pajulo et al., 2001; Suchman et al., 2005). It has been found that many of these children can display behaviour that challenges those around them, and mothers may not always have the capacity or skills to respond effectively (Pajulo et al., 2001). They can be less attuned to their child's needs and more passive or disengaged during interactions with their children (Eiden, Schuetze, & Coles, 2011; Suchman, Pajulo, & Mayes, 2013). Studies have highlighted the importance of interventions that promote positive parent-child interactions (Moreland & McRae-Clark, 2018); however, there is limited research into the efficacy of such interventions that include this element (Hildebrandt, 2020). Previous research has highlighted the importance of substance misuse treatment programmes which are evidence-based (West et al., 2020) and integrated (Andrews et al., 2018), i.e. treating substance use alongside a parenting component

(Neger & Prinz, 2015). Integrated programmes can support mothers with addictions by combining parenting support with addiction services (Espinet et al., 2016). In order to enhance engagement, retention and outcomes, interventions should meet the needs of the population and match risk and protective factors (Supplee, Parekh, & Johnson, 2018).

Integrated programmes are designed to target less effective parenting practices, improve outcomes for children and mothers, and therefore aim to address the intergenerational cycle of addiction (Niccols et al., 2012). The intergenerational cycle of addiction refers to interactions between children and mothers, and the world around them (Bosk, Paris, Hanson, Ruisard & Suchman, 2019). Negative early experiences put mothers at greater risk of substance misuse and abuse or neglect of their own children, who in turn are then at increased risk of developing problems with substance use (Felitti et al., 1998). It is important to examine parenting behaviours, such as parent-child interactions, as these have been linked to improvements in outcomes for children (Latendresse et al., 2008). For instance, programmes which enhance positive parent-child interactions have been shown to reduce the likelihood of disruptive behaviour in at-risk children (Webster-Stratton, Reid & Hammond, 2004).

Niccols and colleagues (2012) carried out a systematic review, examining integrated programmes and outcomes for mothers, for studies published from 1990 to 2011. They found that integrated programmes demonstrated a small advantage over treatment-as-usual, and improvements were associated with attachment-based parenting interventions. They did not find any randomised control trials (RCTs) examining parenting attitudes, parenting knowledge or custody. They recommended that studies should be more rigorous and encouraged future RCTs.

The present systematic review aims to follow on from the Niccols et al. (2012) review by identifying studies published between June 2011 and January 2021, which investigate integrated treatment programmes with a parent-child interaction component, for mothers with substance abuse issues; to appraise the quality and synthesise identified studies.

Specifically, it examines:

- How do studies measure improvement in parent-child interactions?

- To what extent are the integrated programmes effective at improving parent-child interactions according to these measures?

Method

This proposed systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses guidelines (PRISMA; Moher et al. 2009).

Search Strategy

A search of Web of Science Core Collection, EMBASE, MEDLINE, and PsycINFO, CINAHL, Psychology and Behavioural Sciences Collection, Cochrane, Scopus and PUBMED was carried out on studies published between June 2011 and January 2021 in order to follow on from the review carried out by Niccols and colleagues (2012). These databases were selected as they cover a range of fields and disciplines which provide support to people with addictions and their families, including psychology, medicine and nursing. Search terms were developed in consultation with a Specialist Librarian and included Boolean-paired key words related to mothers, substance use and interventions (see Appendix 1.2). The final search was conducted on 4th January 2021. A key journal (Infant Mental Health Journal) was also separately hand-searched along with reference lists of included articles, and the studies citing them.

Inclusion criteria

- Studies with mothers of young children (0-6 years old);
- Participants had substance misuse problems at baseline, confirmed with an addiction severity measure or formal diagnosis;
- Studies which evaluated an integrated treatment programme, i.e. one specific substance use treatment (such as group therapy, methadone) and one parenting component (such as parenting classes).
- Reported measure of parent-child interaction;
- Outpatient setting;

- Published since the Niccols et al. (2012) review, between June 2011 and date of search, 4th January 2021.

Exclusion criteria

- Articles not published in English;
- Case studies, reviews, dissertations, book chapters, study protocols, unpublished or non-peer reviewed articles;
- Qualitative studies;
- Studies focusing only on addictions other than drugs and alcohol (internet addiction, tobacco-only studies).

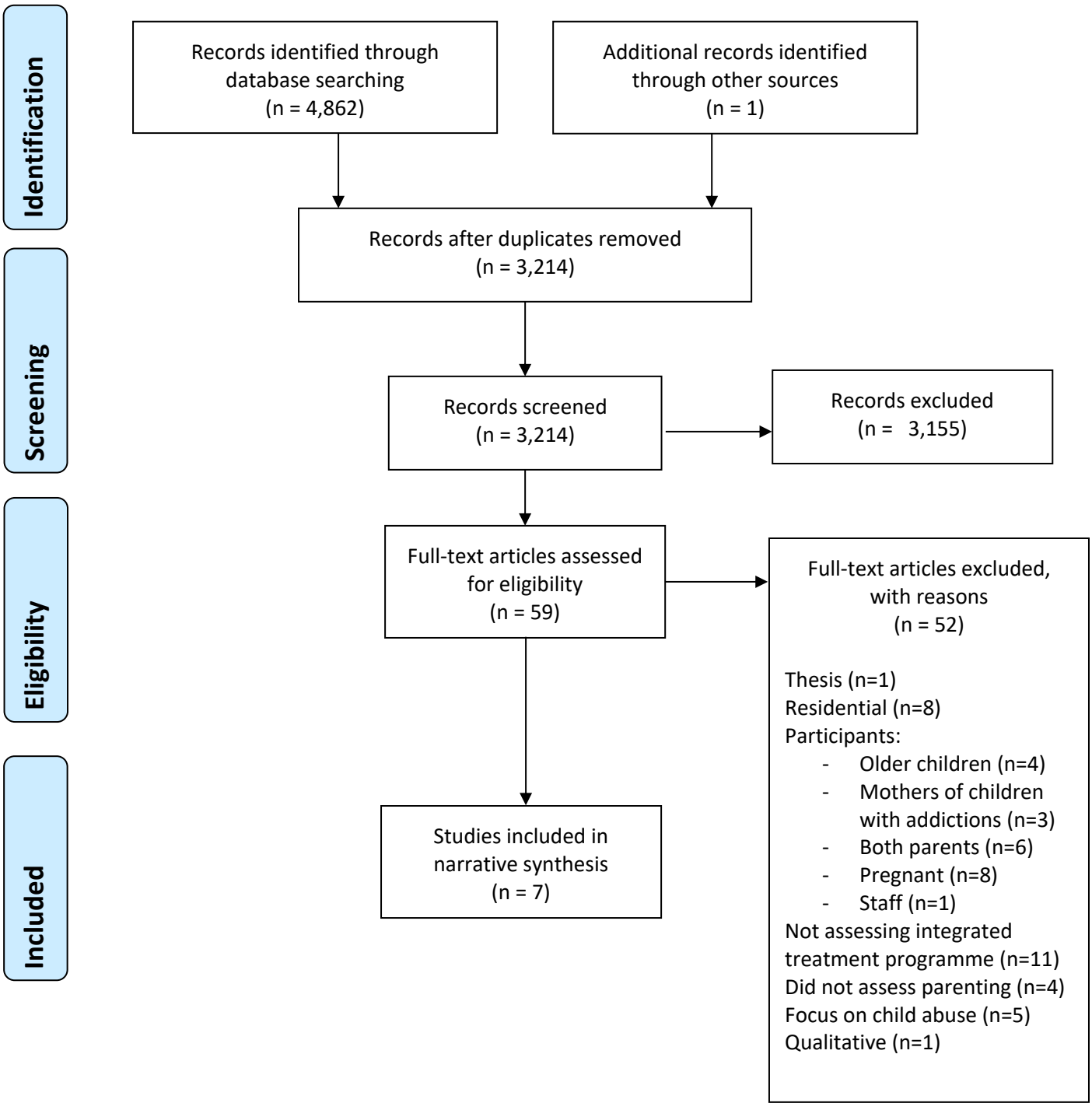
Quality rating

Quality assessment was carried out using The Effective Public Health Practice Project Quality Assessment Tool (EPHPP, see appendix 1.3). This generic tool can be used to evaluate a number of study designs and has been considered suitable for systematic reviews of effectiveness (Armijo-Olivo, Stiles, Hagen, Biondo & Cummings, 2012). The tool assesses six domains: selection bias, study design, confounders, blinding, data collection method and withdrawals. The tool allows for each domain to be rated as strong, moderate or weak, and total scores allow for an overall rating of strong, moderate or weak. The tool has demonstrated fair inter-rating agreement for individual domains and excellent agreement for final grades (Armijo-Olivo et al., 2012).

Results

An overview of the search and screening process is presented in Figure 1. A total of 4,862 articles were identified through database searches and one paper was identified through hand searching, which required full text screening. After duplicates were removed, 3,214 articles were screened, and the eligibility criteria were applied to 59 articles. From this, a further 52 articles were excluded, and the remaining 7 articles were included for data extraction (see Appendix 1.4) and evaluation. No articles identified from manual searches met the inclusion criteria.

Figure 1: PRISMA Flow Diagram



Participants and settings

A summary of study characteristics is presented in table 2. A total of 427 participants took part across 7 studies. Two articles reported on the same data set (Suchman et al., 2017; 2018), and so the sample from the latter study was not included in this figure. Average age of the child was 19.17 months (range 1 month – 60 months). Average age of mother was 29.43 years old (range = 18-42).

The most common reported ethnicity across all studies was Caucasian/white, with an overall average of 72.0% (range 40.6% - 78.6%). The number of African American/black participants varied across studies with an overall average of 16.7% (range = 3.5% - 37.0%). Jeong et al. (2015) did not report ethnicity. Employment rates ranged from 4% – 20% (overall average 13.1%). Hildebrandt et al. (2020) and Porter et al. (2015) did not report employment figures. Rates of married participants ranged from 5% - 16.7% (overall average 11%). Jeong et al. (2015) did not report marital status. Method of reporting educational attainment varied. Gannon et al. (2017) and Jeong et al. (2015) reported percentage completing high school (29.6% and 50% respectively). Four papers (Hildebrandt et al., 2020; Suchman, Decoste, Rosenberger & McMahon, 2012; 2017 & 2018) reported average years in education, with overall average of 12.01 years. The remaining paper reported 78.3% of the sample attained 7-12 years in education (Porter et al., 2015). Ten years and above is High school level in the USA (for further details on participant characteristics see appendix 1.5)

All studies were carried out in outpatient settings, two utilised home visits (Hildebrandt et al., 2020; Porter et al., 2015).

Study Characteristics

Four studies were RCTs (Porter et al.,2015; Suchman et al., 2012; 2017; 2018) and three studies used single group pre/post design (Gannon et al., 2017; Hildebrandt et al., 2020; Jeong et al., 2015).

Six studies were based in USA (Gannon et al., 2017; Hildebrandt et al., 2020; Porter et al., 2015; Suchman et al., 2012, 2017, 2018) and one was based in Canada (Jeong et al., 2015).

Table 1: Study Characteristics, Findings and Quality Rating

Author(s), (Year) Country ***Quality Rating***	**Intervention** **Format**	**Participants** **Samples and characteristics**	**Design and analysis**	**Parent-child interaction measure** **Data collection timepoints**	**Primary Findings**
Gannon et al. (2017) USA *Moderate*	Mindfulness-Based Parenting (MBP) 12-week group-based intervention (2 hours).	N = 160 Age: M= 30.63 (4.27) Age of child= M= 14.89 months (14.02) Ethnicity: Caucasian = 76.2% Employed = 8.6% Education: High school = 29.6%	Single group pre/post. Longitudinal multilevel regression analyses.	KIPS Data collected: baseline and 2 weeks following intervention	Sig. improvements in KIPS total (P < 0.001, ***d*=1.35**). Sig. increase in subscales; building relationships (P < 0.001, ***d*=1.25**), promoting learning (P < 0.001. ***d*=1.29**), supporting confidence (P < 0.001 ***d*=1.39**) Higher mindful parenting predicted improved quality of overall parenting behaviours [***B* =1.22**, P < 0.001].
Hildebrandt et al. (2020) USA	Parent-Child Assistance Program (PCAP) and Infant-Parent Psychotherapy (IPP).	N= 57 (33 PCAP, 24 PCAP +IPP) Age: M= 27.5 (6.1) Age of child= M= 10.7 months (5.2)	Single group pre/post. Combined-sample regression analysis	FEAS Data collected: Pre-test, post-test and 12-month follow up.	Descriptive stats: Overall improved FEAS scores across sample (n=57) – 75.4% scoring within normal range at T1, 91.2% at T2. Improved FEAS scores were significantly predicted by the number of community services

Moderate	PCAP-Home visits (2 per month). IPP – home visits, weekly, 12 months, 1-2 hours.	Ethnicity: Caucasian = 75.4% Employed = N/A Education: M= 11 years (1.7)			received (p<.005, ϕ =.372, ***d = 0.24)*** but not by PCAP management hours. The PCAP+IPP group did not score sig. higher than PCAP-only group on any domains or total scores.
Jeong et al. (2015) Canada *Weak*	Breaking the Cycle Weekly or biweekly, 12 months.	N = 50 Age: M= 29.5 (5.49) Age of child= M= 15.66 months (15.55) Ethnicity: N/A Employed = 4% Education: High school = 50%	Single group pre/ post. Paired t- tests Hierarchical regression analyses	AAPI–2 NLSCY Data collected: At baseline and 12 months	AAPI-2:Increase in scores in attitudes: expectations, (***d*= 0.34***),* empathy toward child's need (***d* = 0.56**), role reversals in relationship (***d*= 0.55)** NILSCY: Results non-sig.
Porter et al. (2015) USA *Strong*	Infant Massage Parenting Enhancement Program (IMPEP) Parent Enhancement Program (PEP)	IMPEP: N=51 PEP: N= 35 Control: N=35 Age: M= 27.8 (SD N/A)	RCT Repeated measures ANOVA	OMII Data collected: at baseline (Week 1), Week 6, and Week 12.	OMII scores increased significantly over time within each of the 3 treatment groups from baseline to week 12 (p=<.001), these changes cannot be attributed to intervention type. OMII scores were higher in the IMPEP and PEP groups compared to control at baseline. Baseline scores were in the highest category '(maximally displayed') during observation (OMII).

	IMPEP: Group, 4 weeks, 2 hours. PEP: group, 4 weeks, 1.5 hours.	Age of child= M= N/A months (range 1-4 months). Ethnicity: Caucasian = 40.6% Employed = N/A Education: 7-12 years = 78.3%			
Suchman et al. (2012) USA *Weak*	Mothers and Toddlers Programme (MTP) Parent Education (PE) 12 weekly sessions, 1-2 hours.	N= 47 (23 MTP, 24 PE) Age: M= 30.21 (6.39) Age of child: M= 18.54 months (12.27) Ethnicity: Caucasian = 70.8% Employed = 13% Education: M years = 12.21 (2.13)	RCT Multiple linear regression analysis	PDI WMCI NCAST Data collected: at baseline, posttreatment, and 6-week follow-up.	Summed scores (PDI+WMCI) = overall RQ Therapist treatment adherence predicted 27% of the unique variance in overall RQ (**$r^2\delta$ = .27**, $p < .05$). NCAST: Greater therapist adherence to intervention associated with improvement in overall caregiving behaviour **(β =.55,** $p < .05$)
Suchman et al. (2017) USA *Moderate*	Mothering from Inside out (MIO) 12 weekly sessions, 1-2 hours.	N= 62 (27 MIO, 35 PE) completed treatment and post- treatment assessments, and 45 mothers (18 MIO and 27 PE) completed the 3-	RCT Regression analyses	PDI WMCI CBP	PDI: Higher RF scores at end of treatment **(*d* = 0.20**), and at 3-months (***d*= 0.36**). WMCI: Higher total scores ('overall coherence') at post-treatment (***d*=0.41**) and 3-month follow-up (***d*=0.54**).

		month and 12-month follow up. Age: M= 29.66 (5.42) Age of child: M= 27.64 months (14.86) Ethnicity: Caucasian = 77.25% Employed = 20% Education: M years = 12.37 (2.13)		Data collected: at baseline and posttreatment, 3-month follow-up and 12-month (Mother–child interaction quality only)	CBP: Higher levels of child involvement post-treatment (***d*= 0.37**) and 12 months (***d*= 0.28**), Maternal sensitivity at 3-months (***d* = 0.21**), 12 - months (**d=0.46**) and dyadic reciprocity at 3-months (***d*= 0.21**) and 12-months (***d*= 0.45**). 1-year follow up-maternal sensitivity (***d*= 0.46**), child involvement with mothers **(*d*= 0.28)** and greater reciprocity (***d* = 0.45**)
Suchman et al., (2018) USA *Moderate*	MIO 12 weekly sessions, 1-2 hours.	62 mothers (27 MIO, 35 PE) completed treatment and post- treatment assessments, and 45 mothers (18 MIO and 27 PE) completed the 3-month and 12-month follow up. Age: M= 29.9 (5.29) Age of child: M= 27.9 months (14.88) Ethnicity: Caucasian = 78.6%	RCT Hierarchical linear regression	PDI WMCI CBP Data collected: Pre- treatment and post-treatment assessments, 3-month and 12-month follow up.	PDI: Self-focused RF Covariate block= **14% variance** ($R^2\Delta$ = .14, medium effect size) - maternal education accounted for **11%** $R^2\Delta$ = .11, medium effect size) of Therapist adherence = **10% variance** ($R^2\Delta$ =0.10, medium effect size) PDI: Child-focused RF Covariate block= **7% variance** ($R^2\Delta$ =0.07, small effect size).

		Employed = 20% Education: M years = 12.44 (2.18)			WMCI Mental rep. of caregiving = therapist adherence = **31% variance** ($R^2\Delta$ =0.31, large effect size) CBP: Caregiver sensitivity Covariate block = **6% variance** ($R^2\Delta$ =0.06, small effect size) at 3 months Improvements in RF and RQ = **8%** ($R^2\Delta$ = .08, small effect size). variance for caregiver sensitivity

Key: KIPS= The Keys to Interactive Parenting Scale, FEAS = The Functional Emotional assessment scale, AAPI-2 = The Adolescent–Adult Parenting Inventory–2, NLSCY= National Longitudinal Survey of Children and Youth, OMII = Observation Checklist on Mother-Infant Interaction, PDI = The Parent Development Interview, WMCI = The Working Model of the Child Interview, NCAST = The Nursing Child Assessment Satellite Training Teaching Scale, CBP = Curiosity box Paradigm (CBP), RQ = representation quality, RF = reflective functioning.

Quality appraisal

To examine the quality of each paper, the EPHPP tool (Thomas et al., 2004) was used. The author and a second-rater familiarised themselves with the EPHPP tool and dictionary, and then the author and second-rater completed independent ratings on three papers initially and compared scores. The second-rater was a third-year doctorate trainee who was independent from the study. Initial agreement rate was 66.7% across total individual items (24/36) and discrepancies were resolved though discussion until 100% agreement was met. Discrepancies centred around the 'selection bias' and 'study design' components and were resolved following a review of the dictionary. A further three papers were co-rated, with an agreement rate of 100%. The final paper was rated by the author.

A summary of each quality item is provided below in table 2. One study was globally rated as strong (Porter et al., 2015), four were rated as moderate (Gannon et al., 2017; Hildebrandt et al., 2020; Suchman et al., 2017, 2018), and two were rated as weak (Jeong et al., 2015 & Suchman et al., 2012).

Methodological strengths included study design, with allocation to a control group (Porter et al., 2015; Suchman et al., 2012, 2017, 2018), and the use of valid and reliable measures (Gannon et al., 2017; Hildebrandt 2020; Porter et al., 2015; Suchman et al., 2012).

Methodological weaknesses included inadequate reporting of the control of confounders (Jeong et al., 2015, Suchman et al., 2012), blinding not clearly described for participants or researchers (Gannon et al., 2017; Hildebrandt et al., 2020; Jeong et al., 2015; Suchman et al., 2012) and not clearly reporting withdrawals and dropouts (Jeong et al., 2015; Suchman et al., 2012, 2017, 2018).

Table 2: EPHPP Ratings

Papers	Selection Bias	Study Design	Confounders	Blinding	Data Collection Methods	Withdrawals and dropouts	**Overall Rating**
Gannon et al. (2017)	Moderate	Moderate	Strong	Weak	Strong	Strong	**Moderate**
Hildebrandt et al. (2020)	Moderate	Moderate	Moderate	Weak	Strong	Strong	**Moderate**
Jeong et al. (2015)	Weak	Moderate	Weak	Weak	Weak	Weak	**Weak**
Porter et al. (2015)	Moderate	Strong	Strong	Strong	Strong	Strong	**Strong**
Suchman et al., (2012)	Moderate	Strong	Weak	Weak	Strong	Weak	**Weak**
Suchman et al. (2017)	Moderate	Strong	Strong	Moderate	Moderate	Weak	**Moderate**
Suchman et al. (2018)	Moderate	Strong	Strong	Moderate	Moderate	Weak	**Moderate**

Outcome Measures

A range of outcome measures were used, with several measures being used in only one study (see Table 1). The outcome measures can be understood by their commonalities. Caregiver sensitivity, warmth and empathy is explicitly examined in five measures (WMCI, OMII, NCAST, CBP and AAPI-2; used across 5 studies). Supporting cognitive growth and appropriate expectations are areas in four measures (KIPS, AAPI-2, OMII and NCAST; used across 4 studies). Reciprocity, engagement and relationship building are examined in three measures (KIPS, FEAS, CBP; used across 4 studies). A mentalisation focused approach was used in two measures (PDI, WMCI; used across 3 studies). Frequencies of daily parent-child interactions was measured with the NILSCY (used in Jeong et al., 2015). Five outcome

measures use observation, two use questionnaires and two use interview methods (for further information of the outcome measures, see Appendix 1.6).

Table 3: Outcome Measures

Measure	Studies included in review	Type
The Keys to Interactive Parenting Scale (KIPS).	Gannon et al. (2017)	Observation
The Functional Emotional assessment scale (FEAS)	Hildebrandt et al. (2020)	Observation
Observation Checklist on Mother-Infant Interaction (OMII)	Porter et al., (2015)	Observation
The Nursing Child Assessment Satellite Training Teaching Scale (NCAST)	Suchman et al. (2012)	Observation
Caregiver sensitivity Curiosity Box Paradigm (CBP)	Suchman et al. (2017, 2018)	Observation
The Adolescent–Adult Parenting Inventory–2 (AAPI–2)	Jeong et al. (2015)	Questionnaire
National Longitudinal Survey of Children and Youth (NLSCY)	Jeong et al. (2015)	Questionnaire
The Parent Development Interview (PDI)	Suchman et al. (2012, 2017, 2018)	Interview
The Working Model of the Child Interview (WMCI)	Suchman et al. (2012, 2017, 2018)	Interview

Interventions

Three articles used a mentalisation-based approach (MIO/MTP; Suchman et al., 2012; 2017; 2018). This intervention is a manual-guided 12-session weekly (2 hours) approach, aiming to improve the quality of relationships between mothers with substance-misuse and their children. It is based on attachment principles and focuses on improving maternal reflective functioning (RF), improving representations of the child and the caregiving relationship.

One article examined the effectiveness of infant massage (IM) integrated into a structured multidimensional Parenting Enhancement Program (PEP; Porter, 2015). The massage condition involved four weekly 2-hour classes of 4-6 mother-infant dyads. These psychoeducational group sessions included massage techniques, group discussions and Q-and-A sessions on child-care. Mothers learned mother-infant communication skills during the sessions.

Breaking the Cycle was examined in one study (Jeong et al., 2015). BTC is an integrated programme that provides service to mothers and children until treatment goals have been met. The duration of the intervention is 12 months – either weekly or bi-weekly. Services include individual substance use and mental health counselling, relapse prevention, parent psycho-education and mother-child intervention through home visits. The main focus of the intervention is on mother-child relationships and improving relationship capacity.

One intervention utilised a mindfulness approach (MBP, Gannon et al., 2017), encouraging greater attention from parents on the interaction with their children, with the aim of enhancing compassion and emotional awareness. Different from the mentalisation approaches (MIO & MTP), MBP focuses on present-moment awareness and is group-based to encourage a social network of mothers. The intervention duration was 12 weeks with each session lasting 2 hours.

Lastly, one study looked at the Parent Child Assistance Programme (PCAP) and Infant Parent Psychotherapy (IPP) (Hildebrandt et al., 2020). PCAP was based on relational theory, motivational interviewing and harm reduction principles. The goal is to develop relationships with an average of two home visits per month. IPP aims to improve attachment quality of parents and understand negative past experiences and their impact on the relationship with their child. IPP sessions were held weekly for 10-12 months (1-2 hours).

In summary, the length of intervention varied greatly, from 4 weeks (Porter et al., 2015) to 12 months (Hildebrandt et al., 2020; Jeong et al., 2015). The majority used individual sessions, but two were group based (Gannon et al., 2017; Porter et al., 2015). Most were weekly, apart from one which used 2 sessions per month (Hildebrandt e al., 2020). Two were based on home visits (Hildebrandt et al., 2020; Porter et al., 2015).

Findings

Six papers reported improvements in parent-child interactions following interventions. Three studies drew their conclusions from the use of observation tools (Gannon et al., 2017; Hildebrandt et al., 2020; Porter et al., 2015), three used a combination of observation and interviews (Suchman et al.,2012; 2017; 2018) and one paper used questionnaires to measure

parent-child interactions (Jeong et al., 2015). According to the quality appraisal carried out (EPHPP), the studies were of a mixed quality (greater detail of results can be found in table 2).

Gannon and colleagues (2017) found improvements in overall interaction scores (as measured by KIPS) following the mindfulness-based intervention (*d*= 1.35, large effect size) and improvements in subscale scores; building relationships (*d*=1.25, large effect size), promoting learning (*d*=1.29, large effect size) and supporting confidence (*d*=1.39, large effect size). They found that higher mindful parenting predicted improvements in overall parenting behaviours (*d*= 1.22, large effect size).

Small effect sizes were reported in the Hildebrandt et al. (2020) study for the Parent-Child Assistance Programme (PCAP). They found that interaction scores (as measured by FEAS) were significantly predicted by number of community services received (*d*= 0.24, small effect size). They noted that the percentage of the sample scoring within 'normal' range for interaction improved, from 75.4% at T1 to 91.2% at T2. The inclusion of additional Infant-Parent Psychotherapy (IPP) component did not yield significant results.

Porter et al. (2015) examined whether the addition of an infant massage component would improve parent-child interaction, compared to Parent Enhancement Programme (PEP) alone. Using an observation checklist (OMII) they found that scores increased significantly over time within each of the 3 treatment groups (IMPEP, PEP and control) from baseline to week 12 (p=<.001), and these changes could not be attributed to intervention type. OMII scores were higher in the IMPEP and PEP groups compared to control at baseline.

Suchman et al. (2012; 2017; 2018) used observation and interview methods to examine the impact of their Mothering from Inside Out programme (MIO, formally MTP). They studied the impact of the intervention on mentalisation skills - reflective functioning (RF) and representational quality (RQ) (measured by PDI and WMCI respectively) and caregiving behaviour (measured by the NCAST/CBP). In their 2012 study, they found that therapist treatment adherence accounted for 27% of the variance in overall reflective representation (summed scores for the PDI + WMCI). Greater therapist adherence to the intervention was also associated with improvement in caregiving behaviour (β =.55, $p < .05$). Scores from the

quality appraisal tool (EPHPP, Thomas et al., 2004) suggest that confounders and blinding were not adequate described in their 2012 study, however, and they recommended that results should be treated with caution.

In a further RCT, Suchman and colleagues (2017) found higher RF scores (small effect sizes) at the end of treatment (*d*= 0.20) and at 3-months (*d*= 0.36). In their measure of the mothers' internal working model of the child (WMCI), they found higher total scores ('overall coherence') at post-treatment (*d*= 0.41) and 3-month follow up (*d*=0.54). They noted improvements with small effect sizes in all subscales of their interaction observation tool (CBP) at 12-months; child involvement (*d*= 0.28), maternal sensitivity (*d*= 0.46) and dyadic reciprocity (*d*= 0.45).

Following on from this, in 2018 they hypothesised that improvements in mentalisation skills (measured by PDI & WMCI) would lead to improvements in caregiving sensitivity (measured by CBP). They separated reflective functioning into self-focused and child-focused. They found that the covariate block (child age, child gender, maternal education) accounted for 14% of the variance in self-focused RF, and 7% of the variance in child-focused RF. Therapist adherence accounted for 10% of the variance in self-focused RF and 31% of the variance in mental representation of caregiving (as measured by WMCI). They found that even after controlling for the covariates noted above, and changes in psychiatric distress and substance use, improvements in RF and RQ together accounted for 8% of the unique variance (small effect) for caregiving sensitivity, supporting their hypothesis.

One study in this review examined parent-child interaction using questionnaires to assess improvements in parenting attitudes (AAPI-2) and behaviours (NILSCY) (Jeong et al., 2015). Similar to the Parent-Child Assistance Program (PCAP) examined by Hildebrandt et al. (2020), Breaking the Cycle (BTC), is a program from which mothers can access a variety of treatments and support. Jeong et al. (2015) found an increase in scores across the attitudes measure (AAPI-2); parental expectations, (*d*= 0.34, small effect size*),* empathy toward child's need (*d* = 0.56, medium effect size), role reversals in relationship (*d*= 0.55, medium effect size). They did not find significant results for their interaction measure (NILSCY), noting a 'ceiling effect' where reported interactions were already elevated at intake.

Discussion

The purpose of this review was to investigate integrated treatment programmes with a parent-child interaction component for mothers who misuse substances. The aim was to appraise the quality and synthesise identified studies. Specifically, it sought to examine how parent-child interactions were measured and to what extent programmes were effective at improving interactions, according to these measures.

Seven papers were included in the narrative synthesis. Interventions varied in focus, which included: 1) substance-misuse recovery, with elements of relapse prevention and motivational interviewing; 2) practical parenting skills, using psycho-education; 3) parent-child relationship building through infant massage, improving mentalisation skills, or mindfulness skills.

There was also diversity in the range of outcome measures used to capture different areas of parent-child interactions:1) caregiver sensitivity, warmth and empathy; 2) supporting cognitive growth and appropriate expectations; 3) reciprocity, engagement and relationship building; 4) reflective functioning and representational quality within interactions. Three studies used observation and interview measures (Suchman et al., 2012; 2017; 2018), three used observation measures (Gannon et al., 2017; Hildebrant et al., 2020; Porter et al., 2015) and one study utilised self-report measures (Jeong et al., 2015). It is important to note this variety of measures used as previous research has highlighted that self-report measures in this field can be problematic (Holden, 2001) and associations between self-report and observed parenting behaviour has been found to be weak (Hendriks, Van der Giessen, Stams & Overbeek, 2018).

This diversity in interventions and outcome measures means that caution should be exercised when interpreting the findings of this review as generalisability is limited. This limited ability to make comparisons across studies is a significant issue for research in this area.

Six papers reported improvements in parent-child interactions following intervention. Previous research highlighted that difficult interactional patterns can be found in mothers who use substances and their children (Pajulo et al., 2001; Suchman et al., 2005; Eiden, Schuetze, & Coles, 2011; Suchman, Pajulo, & Mayes, 2013) so the results are promising.

However, the quality of studies varied, as did the effect sizes reported. Gannon et al., (2017) reported improvements in interactions, with large effect sizes, following their mindfulness-based intervention, using the KIPS observational tool. The global quality appraisal for this study was in the moderate range, with a weak score given to a lack of detail in reporting blinding of participants and assessors. Hildebrandt and colleagues (2020) described a greater number of their sample fell into the 'normal' range following intervention, as measured by the FEAS observational tool. They also received a score of moderate overall, with a weak score for a lack of reporting of the blinding methods of participants and assessors. This is important to note, as blinding of participants and assessors aims to prevent reporting bias.

Three studies were carried out by Suchman and colleagues (2012, 2017, 2018), examining Mothering from Inside Out (formally Mothers and Toddlers Programme). This intervention is mentalisation-based, and they measured reflective functioning (RF) and representational quality (RQ) as facets of positive parent-child interaction. They found that treatment adherence predicted 27% of the variance in RQ (2012), significant improvements in reflective functioning and engagement with small effect sizes (2017, 2018), highlighting mechanisms of change. Interestingly, 14% of the variance in self-focused RF was accounted for by the covariate block, with 11% accounted for by maternal education. This is important to note, as it highlights the importance of controlling for confounders. It would appear from the quality appraisal that a limitation in the Suchman et al. (2012; 2017; 2018) studies is the lack of clarity over withdrawals and dropouts in their sample.

Examining the intervention 'Breaking the Cycle', Jeong et al. (2015) found improvements in scores of empathy and role reversals in relationships, with medium effect sizes, as measured by the AAPI-2. They did not find significant results for their interaction measure (NILSCY) due to a 'ceiling effect'. The global score for this paper was weak, due to inadequate reporting of confounders, blinding, data collection methods and withdrawals and dropouts. Results for the study should therefore be treated with caution.

In their review, Niccols et al. (2012) concluded that there was a lack of consistency across studies, making comparisons difficult. This review sought to identify if improvements in consistency and rigour had been made in the field. Although developments have been made in this area, in terms of RCTs being carried out, it appears improvements could still be made to the consistency, standardisation and quality in this area of research. Similar results have

been reported in systemic reviews in the field of substance misuse (Martinez-Vispo et al.; 2018) and may reflect the complexity of research in this field. Martinez-Vispo et al. (2018) called for improvements in homogeneity of studies for reviews. The present review used clear inclusion and exclusion criteria as an attempt to achieve homogeneity. A strength of this review is the focus on interventions that specifically include young children, as interventions targeting younger and older children may be very different from one another (Moreland and Mc-Rae Clark, 2018).

Regarding the quality of studies, it is important to note that only one study reached the qualification of strong methodological quality (Porter et al., 2015). However, they did not find significant change in parent-child interaction in their study. They concluded that the length of the duration of intervention (4 weeks) may have not been adequate to capture change. Also, due to high attrition they only analysed data until week 12, when infants were 4-7 months which they highlight is younger than the recommended age for the reunion scenario in their outcome measure (OMII). According to the quality appraisal tool (EPHPP, Thomas et al., 2004), the study was globally rated as strong, however it was given a moderate score for selection bias, which could be improved if participants were randomly selected from a comprehensive list of individuals, rather than from a single source. It may also be that by adequately controlling for confounding variables, significant differences were less apparent.

Limitations

There are a number of limitations to this review which should be considered when interpreting the findings. Firstly, while every effort was made to carry out a rigorous search, it is possible that relevant studies may have been missed. In addition, one researcher defined the inclusion and exclusion criteria, conducted searches and selected studies, which may lead to selection bias in the review. Systemic reviews would typically require more than one person being part of the screening process, but this was beyond the scope of the present study. It is also important to note that only English-language, published, peer-reviewed papers were included which puts the review at risk of cultural bias and publication bias. Two articles identified in this review used the same dataset and intervention (Suchman et al., 2017; 2018), which may lead to overrepresentation in the synthesis.

Similar to previous studies (Niccols et al., 2012; Martinez-Vispo et al.; 2018) the studies included in this review varied in terms of design, quality and intervention which makes comparisons challenging. Sample sizes across studies were small, which may have impacted the reliability of the studies. The majority of the studies were carried out in the USA and only one in Canada. Given differences in culture and in health and social care, between the USA and other countries, it may be difficult to generalise findings to populations outside of this context.

In terms of quality appraisal, there was a great deal of variation across studies. Adequately describing the blinding process and explaining withdrawals and drop-outs were two areas in which studies scored poorly. It is important for papers to describe drop-outs in order to accurately describe findings, particularly in populations which previous research has highlighted high drop-out rates (Cox, 2000; Greenfield et al.,2007;Brady and Ashley, 2005; Poole & Isaac, 2001; Kail & Elberth, 2002).

This review sought to investigate studies which have examined integrated treatment programmes with a parent-child component for mothers who misuse substances. These programmes aim to improve parent-child relationships, in order to have a long-term impact on the child's well-being and break the intergenerational cycle of addictions. The findings suggest that improvements can be found in parenting behaviour, such as caregiver sensitivity (Suchman et al., 2018) and supporting confidence in their child (Gannon et al., 2017). However, it should be acknowledged that there is a distinction between changes in parent-child interaction and long-term impact on outcomes for children. Studies have yet to examine improved long-term outcomes for children, following these integrated interventions. This is in line with previous research into parenting programmes, which highlighted the complexity of drawing conclusions on the outcomes for children based on the outcomes for parents (Bloomfield & Kendall, 2012).

Clinical implications and future research

This review found evidence of improvements in parent-child interactions in the majority of studies. However, any recommendations to include a parent-child interaction element into an intervention programme at this stage would be tentative given the methodological and quality issues discussed.

Future research would benefit from examining commonalities across parent-child interaction measures, in order to seek a more standardised measure to determine effectiveness of interventions. Further high-quality studies are needed, with larger sample sizes. It would be important for research in this area to be carried out in a greater variety of health and social care contexts outside of the USA. Without this further research it is difficult to generalise findings to other populations. It would also be important to examine if any changes to the parent-child interactions are long-term and longitudinal studies would be helpful to explore the impact on the intergenerational cycle of additions (Bosk, Paris, Hanson, Ruisard & Suchman, 2019).

Finally, future research should clearly describe withdrawals and drop-outs to programmes so that improvements can be made to engagement rates, particularly in this population which can be hard to retain.

Conclusion

Studies had previously highlighted the need for research into the effectiveness of incorporating parent-child interaction element to parenting programmes (Moreland & McRae-Clark, 2018; Hildebrandt, 2020). This review contributes to the literature base by highlighting recent studies in this area, how they measure parent-child interaction, and if improvements are found. Although more research is required in order to support the effectiveness of including parent-child interactions into a parenting intervention, the studies in this review showed promising and suggestive data. Future studies of high quality are needed to examine this further.

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Chapter Two

Major Research Project: The Experience of Staff working with Mothers in Addiction Services who have had their Children Removed.

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Plain Language Summary

Background

Mothers who misuse substances often struggle with a range of difficulties and parenting can be challenging for them. In some circumstances their children may be removed from their care. It is important that these mothers receive support with this from staff members working in recovery services. However there is a lack of research into how staff feel about this role.

Aims

This study aimed to explore the experiences of staff members in recovery services working with mothers who have had their children removed. It also aimed to find out what their experiences are of working with other professionals and what training would help them in their role.

Methods

Participants were six staff members in a took part in interviews which were recorded. These were analysed by the researcher, who kept their identities private.

Results

The participants described their experiences of working with mothers who have had their children removed. Their experiences were summarised into themes: 1) Complexity and tension within working relationships; and 2) Emotional experiences and attempts to resolve these. The participants described how it could be challenging to work with the mothers after their children were removed and how they would work hard to provide support. They felt they would benefit from training into what the mothers experience.

Summary

The findings provide a valuable insight into the experience of staff members working in this role. Their experiences suggest it can be challenging for them trying to balance all aspects of their job.

Abstract

Background

Studies have found high levels of trauma, poverty and domestic abuse for mothers who misuse substances (Mandavia, Robinson, Resslet & Power, 2016). Research has demonstrated that substance misuse in mothers can be associated with parenting difficulties and risk of child maltreatment (Kelley et al., 2015), and that these mothers may be limited in their ability to respond effectively to their child's needs (Pajulo, Suchman, Kalland & Mayes, 2006). Successful treatment of substance abuse relies on these women gaining effective support from services. Previous research has demonstrated the impact working in this field can have on staff, including high staff turnover, vicarious trauma and burnout (Chen & Scannapieco, 2010).

Aims

To explore the experience of staff members working in drug and alcohol recovery services who with mothers who have had their children removed.

Methods

A qualitative approach analysed secondary data using Interpretive Phenomenological Analysis (IPA).

Results

Two superordinate themes were developed from the data: 1) Complexity and tension within working relationships; and 2) Emotional experiences and attempts to resolve these.

Conclusions

The participants described their experiences of working with mothers who have had their children removed and the complexity of this role. They highlighted their attempts to cope with the emotional impact of being part of this process and the challenges of working within the wider team. Implications and recommendations are discussed.

Keywords: drug misuse, parenting, qualitative research, child welfare, staff perspective

Introduction

Substance misuse among mothers is a serious issue for parenting and poses a significant burden to society. Research has demonstrated that substance misuse in mothers is associated with parenting difficulties and risk of child maltreatment (Kelley et al., 2015), and that these mothers may be limited in their ability to respond effectively to their child's needs (Pajulo, Suchman, Kalland & Mayes, 2006). In Scotland, 16,068 children were 'looked after' (in the care of the local authority) or on the Child Protection register between 2018-2019 (Children's Social Work Statistics, Scottish Government). Parental substance abuse was identified as a concern in 1,061 of case conferences, with similar figures to domestic abuse and neglect. In the period 2016-17, 2,954 women were on the Scottish Drug Misuse Database (Information Service Division (ISD) & National Statistics, 2018) and a further 3,815 were on the Drug and Alcohol Waiting Times database.

Studies have highlighted the needs of mothers who misuse substances, demonstrating that there are often associated issues such as complex trauma, mental health difficulties, poverty and experiences of domestic abuse (Mandavia, Robinson, Resslet & Power, 2016). It can be argued that women in addiction services who have had their children removed may be additionally traumatised. Studies have shown that the removal of a child is likely to be a traumatic loss, and is associated with shame and stigma, and a perception of being a 'flawed mother' (Morriss, 2018). In order to meet these complex needs, research has highlighted the importance of care which is multi-sectoral, integrated (Andrews et al., 2018) and trauma-informed (Farley, Golding, Young, Mulligan & Minkoff, 2004; Douglas, et al., 2010). Andrews and colleagues (2018) also highlight the importance of relationships – between mother and service provider, among staff, between staff and management and between community partners. These relationships are seen as crucial for effective service delivery.

Research and Government guidelines (Department of Health, 2007) have highlighted the importance of healthcare practitioners in the effective treatment of substance misuse. However, there is a lack of research into how staff perceive and understand this role, particularly in the field of parent substance misuse (Whittaker et al., 2016). Whittaker et al. (2016) carried out a focus group with staff working with parents who misuse substances. They found that professionals report a burden of care, and anxiety over their sense of responsibility working with this population. A further focus group examined the experiences

of therapists working in this field and found that the role was viewed as emotionally exhausting (Wiig, Halsa, Bramness, Myra & Haugland, 2018). At the system level, barriers to best practice include declining resources (Whittaker et al., 2016), restrictions on service delivery and the complexity involved in providing a service to a population with high relapse rates and comorbid mental health difficulties (Festinger, Rubenstein, Marlowe, & Platt, 2001; McGovern, Xie, Segal, Siembab, & Drake, 2006). These pressures can filter down to the staff level, which can lead to burnout and high turnover (Chen & Scannapieco, 2010).

Being part of a process that involves child-removal and providing support to vulnerable mothers is likely to be highly emotive for staff and there is a need for research into how staff feel about engaging in this type of work (Cosden, Sanford, Koch & Lepore, 2016). Workers may feel uncomfortable with trauma-informed practice, with trepidation centred around a lack of training, fear around exacerbating difficulties and not having the resources or time (Kunins, Gilbert, Whyte, Meissner & Zachary, 2007). Previous studies have highlighted the risk of staff developing vicarious trauma (Bride, Hatcher & Humble, 2009; Bride & Kintzle, 2011; Elwood, Mott, Lohr & Galovski, 2011; Green et al., 2011). Vicarious trauma is a psychological response that can develop as a result of engaging empathically with clients who have been exposed to trauma. Signs of vicarious trauma can range from a reduction of empathy towards clients to symptoms associated with Post-Traumatic Stress Disorder (PTSD). There is also the potential for positive outcomes, such as Post-Traumatic Growth (PTG), in this area for staff who have experienced trauma (Cosden et al., 2016). Definitions of PTG, which is also known as adversarial growth, include a greater appreciation of life and improved relationships and increased spirituality (Calhoun & Tedeschi, 2013).

It is clear from the literature that this is a complex area of study, with research highlighting the demands on services and staff to provide effective support to mothers who have had their children removed. Studies have highlighted the impact trauma-focused work can have on staff generally, but there is a lack of research with staff working in addiction services specifically (Huggard, Law and Newcombe, 2017). Research has demonstrated the importance of the staff-client relationship and that further research should be carried out to examine staff members' experiences of this relationship. In particular, there is a limited research looking at the lived experience of staff working with mothers who have had their children removed and the impact removal has on them, the relationship with the mother and the service as a whole.

Aims

The aim of this study is to describe the experiences of staff members working with mothers who have had their children removed.

This exploration was guided by the following questions:

1. How do staff members experience working with mothers who have had their children removed?
2. How do staff make sense of the wider system around them, such as multi-disciplinary team working, and their role within this?
3. How do staff understand and report the challenges associated with this role and the resultant training needs?

Method

Design

This study involved secondary analysis of qualitative data, using Interpretive Phenomenological Analysis (IPA) to explore how staff report their experience of working with mothers who have had their children removed. IPA is theoretically underpinned by phenomenology, hermeneutics and idiography (Pietkiewicz & Smith, 2014). Phenomenology is concerned with the way things appear to participants in their experiences and the essential aspects of the experiences which make them unique. Hermeneutics is concerned with the mindset of the participant and the language they use, and researcher's attempt to understand as much as possible what it is like to be the person and use interpretation to make sense of the individual's world. The researcher's attempts to make sense of participants' meaning-making is known as double hermeneutics or dual-interpretation process. Finally, idiography involves the in-depth analysis of single cases before making general comments or cross-case comparisons. In summary, IPA helps the researcher to examine and seek insight into the participants' experiences, how they make sense of their experiences while acknowledging the impact of the researcher's own interpretation of this (Smith & Osborn, 2015).

Ethics

Approval for use of the data in the present study was granted via an amendment to the original study (Ref: GN17MH627, See appendix 2.1).

The original researcher who collected data was a female clinical psychologist working in the team. Staff interviews were carried out with colleagues. The original research addressed potential concerns around confidentiality by making it clear to participants that no identifiable information would be shared with service managers. The researcher for the present study does not work in the service, which may help to reduce bias in the analysis.

Data were handled following GDPR guidance (2018), local Good Clinical Practice (2017) and local data governance guidelines. Anonymised transcripts and interview recordings were made available to the researcher via a restricted access shared drive on a secure University of Glasgow server.

Recruitment and procedure

The data analysed in the present study were originally collected as part of a separate study and the description of the participants, materials and procedures that follows relate to this original study.

During recruitment, staff were made aware of the study through their team leads and provided with information from the chief investigator during team meetings. Staff who were interested in taking part in the study could then contact the chief investigator directly. One-to-one semi-structed interviews were carried out in private clinic space, and they lasted approximately one hour (Range 32 – 68 minutes, Average 43 minutes). These were audio-recorded using a Dictaphone. The original researcher developed a semi-structured interview schedule (Appendix 2.2) following discussion with staff members and from experience working in this field.

Participants

Participants recruited for this study were staff working in an Alcohol and Drug Recovery service in the west of Scotland. There were 14 interviews carried out in total, with participants from different teams. To strive for homogeneity in the sample, a subset of these interviews was selected so that the participants were from a team that work closely with mothers and the participants all had experience of working with mothers who have had their children removed. Therefore, the present study sample was six participants in total, five female and one male. Each took part in a one-off interview. Participants were required to be current staff, English speaking and over 18 years old, with experience working with mothers who have had children removed.

Table 1: Participant Information

Participant	Role	Years in role
1	Senior Social Care Worker	>10 years
2	Senior Addictions Nurse	>10 years
3	Social Care Worker	>10 years
4	Social Care Worker	>15 years
5	Senior Social Care Worker	>15 years
6	Senior Addictions Nurse	1-5 years

Sample size

According to the philosophy of IPA, Smith, Flowers and Larkin (2009) argue that a sample should be small enough to allow for sufficient idiographic analysis. The sample size for the present study is 6 participants, in-keeping with the recommended sample for a doctoral level thesis using IPA of between 4-10 participants (Pietkiewicz & Smith, 2014). This small sample size allowed for a close examination of the participants' lived experiences, focusing on depth of analysis rather than breadth of data (Smith et al., 2009). Braun and Clarke (2013)

suggest that sample sizes should be enough to develop a rich understanding of experiences, but not too much that time constraints prevent an in-depth analysis of the data.

Analysis

Interpretive Phenomenological Analysis (IPA, Smith et al., 2009) was used for this study. Data analysis followed a 6-step process outlined in Smith et al. (2009). These steps included (1) reading and re-reading transcripts; (2) initial noting; (3) developing emergent themes; (4) searching for connections across emergent themes; (5) moving to the next case; and (6) looking for patterns across cases. A summary was written for each transcript to ensure the principle of idiography was withheld (for an example of a transcript summary, see appendix 2.3). Patterns identified across cases were clustered into superordinate themes, creating higher order organisation. For transparency, excerpts of the analysis stage are included in the appendix (2.3).

Researcher characteristics and Reflexivity

The primary researcher was a female, trainee clinical psychologist with experience working with multidisciplinary staff teams. The participants were not known to the researcher and the researcher has not worked in alcohol and drug recovery services, including the recruiting site. The researcher does not have children.

A number of steps were taken to ensure rigour during data analysis. Firstly, in addition to the primary researcher, the academic supervisor read two transcripts and the associated emergent themes, allowing interpretations to be discussed. Alongside this, a research diary was used for the duration of the study. This allowed for an acknowledgment, or 'bracketing off' (Smith et al., 2009), of the researcher's assumptions and preconceptions. The research diary also served to encapsulate the decision-making process during the development of themes, aiding reflexivity and transparency. The researcher discussed any known assumptions or biases prior to data analysis in supervision and sought to maintain a reflective stance throughout.

The study used the consolidated criteria for reporting qualitative research (COREQ) checklist (Tong, Sainsbury & Craig, 2007, see appendix 2.4). The researcher developed a summary for

each interview to help the analysis to remain grounded in the participant's narrative (see appendix 2.3).

Results

Analysis resulted in two interrelated superordinate themes and 5 subordinate themes (Table 2). Themes are illustrated with substantiating excerpts or quotations from transcripts, with line numbers in brackets.

Table 2. Superordinate and subordinate themes

Superordinate Themes	**Subordinate Themes**
Complexity and tension within working relationships	Duality of role: "*I felt like I was really part of that child being removed"* Response to removal*: "become an absolute* pest*, you know …a good pest"* Working with the wider MDT: *"we are not compatible with them"*
Emotional experiences and attempts to resolve these	Emotional impact and empathy*: "my world would be* destroyed *if anybody took my children"* Complexity within attempts to cope*: "I don't mean you become desensitised..."*

Table 3 Representation of participants across themes

	Themes				
Participant	Duality of role	Response to removal	Working with wider MDT	Emotional impact and empathy	Complexity within attempts to cope
Emma	x	x	x	x	x
Peter	x	x	x	x	x
Susan	x	x	x	x	x
Claire	x	x	x	x	x
Libby	x	x	x	x	x
Dawn		x	x	x	x

Complexity and tension within working relationships

Across narratives, the participants convey the complexity of the role and describe how they navigate relationships; both with their clients and the wider team. Their accounts illustrate tension between their professional role, and their contribution towards potential child removal, and wanting to show empathy and alliance with the mothers. Their accounts suggest an ambiguity at times over where they position themselves and their professional identity.

Duality of role: "I felt like I was really part of that child being removed"

Across interviews, the participants portrayed a sense of tension in their job; between their role to support clients and their overall professional duty of care for their clients' children. Participants explained how the nature of their role means that they provide support but will also give evidence at Child Protection and social work meetings regarding their clients' substance use and ability to care for their children. Emma described that her work with the mothers can be *"kind of seen as punitive…you try and balance that"* (220). Emma's account conveys a sense of a harshness, and she does not specify who sees her work as punitive but she perceives judgement on the way she works with her clients. Emma's account also describes an attempt to balance it by being "*transparent*" (92), which suggests an awareness and proactive attempt to mitigate the perceived harshness. Her account suggests an awareness of the negative impact of that aspect of her role, and a conscious effort to reduce this impact and restore trust by being seen to be open and honest.

A perceived scrutiny is also described by Susan, who feels that during Child Protection meetings: "*all eyes are on you*" (38). Being responsible for gathering evidence and the impact of this on staff is further illustrated by Emma. Her account highlights that not only can staff fall into opposing roles of supportive and punitive, but that she perceives that staff and clients can find themselves in conflicting roles:

> *"I am like a detective, because it is trying to catch them out, which doesn't feel nice either, like you are trying to catch somebody out, sometimes it feels like a bit of a cat-and-mouse game with them"* (Emma, 338-340)

Emma uses vivid language to describe her position, with imagery of a hunt. The description conveys opposing roles of cat/mouse or detective/criminal, and suggests an uneasiness with this role; it "*doesn't feel nice*" (339) to play the role of pursuer. Her description suggests discomfort over this position that her duty of care to children means she is actively trying to "*catch [mothers] out*" (339-340). Carrying out this role to protect children means that children may be removed from their mother's care.

The challenge of being part of a system in which women lose "*complete care of their children*" (39) whilst trying to engage them in clinical work is illustrated by Peter:

> *"…we need to…provide that information and at the same time try and encourage mum to work with us, to ask them to trust us when what we have done is, I suppose they might see it as being the biggest, the worst that we can do"* (Peter, 40-43)

Peter describes a tension between providing information that could be viewed as detrimental to the mothers, whilst also engaging them in therapeutic work. He articulates the difficulty of maintaining trust and effective working relationships when he perceives that the mothers may feel he has done the "*worst*" thing. His account is tentative, using "*I suppose*" and acknowledging that the mothers might see it that way, but not describing how he sees it.

The participants highlight a potential breakdown in the working relationship following removal and the challenge of trying to support mothers when they are "*very angry*" (Susan, 297) and "*the relationships could be volatile*" (Libby, 16). Susan's account furthers this, by alluding to how it feels to be part of the removal process:

> *"it is harder when…the child gets removed while you are working with them because you feel like you are contributing to that."* (Susan, 33-35)

She illustrates that it is more difficult if removal occurs while she is working with mothers and later in her interview she explains that it can feel like a "*betrayal*" (338). Her account suggests a distinction between it being difficult working with mothers who have had children removed, but even "*harder*" if they are part of that. This was also illustrated by Emma articulating the sense of responsibility and guilt she felt:

> *"I will never forget the first case that I worked with and the child was removed…I felt really guilty because I'd this good relationship with this client erm and then I felt like I was really part of that child being removed…"* (Emma, 74-77)

Emma's repetition of "*really*" emphasises the strength of guilt she felt. Her account conveys the powerful and lasting impact the experience had on her. She also highlights the shift in the relationship by providing the contrast, "*I'd this good relationship*…".

Response to removal: "become an absolute* pest*, you know …a good pest"

The participants describe their behaviour following a removal. Claire highlights that she has perceived a sense of blame for the removal and how she attempts to manage this:

> *"if a child is removed and then you need to keep a relationship going with that person, who is totally traumatised. Sometimes you get blamed, however, if you persevere with that person, and for me I always say 'so what are we going to do about this?'... to include myself in that overall picture."* (Claire, 35-39)

Her description conveys a sense of responsibility and pressure to maintain the relationship despite the difficult dynamics after a child's removal from care. It appears from her account that her response to getting blamed is to go into a collaborative, problem-solving mode. Her narrative highlights further complexity in the role, being both part of the problem and then part of the solution.

The participants attempt to make sense of the changes in their relationships with the mothers and their attempts to reengage them. Across accounts, their descriptions convey an impression of pushing towards the mothers, and a tension between respecting the mothers' autonomy whilst striving proactively to help them. This is illustrated by Claire:

> "…[I'll] *be up rattling their doors, you know become an absolute* pest*, you know …a good pest, you know you go up chapping their doors, shouting through their letterbox, '... we can fix this"*" (Claire, 70-73)

She perceives herself as a "pest", acknowledging that she feels bothersome to her clients. Her description is vivid, and the imagery it evokes of rattling and chapping doors, gives the impression of insistence and perhaps desperation to reach the client. There is a sense of determination to "*fix*" the situation. This echoes her earlier account, and the perception that she is part of the problem and so wants to be part of the solution.

This is mirrored in Peter's account, as he states "*you need to keep goading*" (174) mothers to attend meetings. The use of "*goading*" is interesting and gives the impression of pushing someone into something and annoying them. The languages used portrays an image that the mothers are reluctant and are being driven to engage by the participants. This is further highlighted by Emma:

> *"myself and a few of my colleagues will physically go and pick people up and take them places just the first time*" (Emma, 210-211)

In her account Emma uses a figure of speech, of picking someone up, and it conveys an impression of unwillingness from the mothers, and physically going to get them suggests a certain lack of autonomy. The description of physically picking someone up is interesting and powerful, and alludes to an image of participants picking up the mothers, like a mother picking up a child.

Libby provides some understanding of why participants may feel a desire to push mothers into engaging. She describes that, following removal when a mother's "*anxiety levels are going through the roof*" (94), she'll tell them:

> "'*you can turn this around and you can you get your child back… but you need to participate* '" (Libby, 97-98)

Her tone appears firm and direct with a focus on problem-fixing rather than giving space to the mother's anxiety.

Working with the wider MDT: "we are not compatible with them"

When describing their relationships with the wider team, the participants give the impression of frustration within these professional relationships. There is a sense of tension, and the participants describe an incongruence between how they work with the mothers, and how colleagues, such as social work, do:

> *"I think after [the child's removal] that they [the mothers] expect us to drop them the way social work drop them"* (Emma, 126)

Emma's view that mothers are "*dropped*" (240) is emotive and powerful, and she highlights a contrast between her team and social work. This image also juxtaposes with her earlier description of when she will "*physically…pick [mothers] up*" (210-211), and is perhaps evocative of a neglectful mother dropping a baby. Five out of the six participants expressed differences in priorities to other members of the MDT. Peter offered an insight into the incompatibility with other members of the team:

> *"…although we are completely integrated with our social work colleagues, we are not compatible with them"* (Peter, 238-239).

Peter's account of being integrated but not compatible suggests friction, and he describes a "*conflict of thought processes" (225).* He repeats the word "*conflict*" a number of times (224, 225, 228) when explaining his work with them. He also describes his experience of being told by managers to carry out a piece of work with a client, work that he believes will not be in the client's best interest:

> "*you are directed…to do something completely alien…our clients will say sometimes that we don't listen to them, that's the times when we feel like managers don't listen to us…."* (Peter, 257-262)

In this account, Peter is describing his frustration at not being listened to by managers when he disagrees with their decisions. His description suggests a parallel process, as he relates this back to times when clients are frustrated with him, which suggests an empathy and understanding of what clients go through. His description also conveys powerlessness and

reluctance. His account illustrates that he has built a relationship and knows what will not work for his clients; "*you know it's never going to work, but you are directed* (270-271). This is echoed by Libby:

> *"are we setting, are they setting them up to fail…quite possibly they are, aye"* (Libby, 188-189)

Importantly, Libby shifts from using "*we*" to "*they*", which suggests a separation between her team and the wider team. Libby and Peter's accounts illustrate a contrast between the relationship they have built with clients, knowing what will help, and a flawed system that is not always able to meet client's needs. The use of "*setting them up*" suggests a perception of an inevitability of failure and, like Peter's account, this implies a sense of powerlessness.

However, the relationship with the wider team is not solely described negatively and there is an impression throughout accounts of participants trying to be balanced about fellow professionals:

> "*what I hear is they (social work) have got really big caseloads…*" (Claire, 262)

There is a sense from the accounts that participants do not wish to appear too critical:

> *"I am not like erm saying anything bad about social work as such, but, because they definitely have got a massive role to play and it is a very challenging job"* (Emma, 234-236).

Emma uses emphatic language, "*definitely*", "*massive*" and "*very challenging*", in her description of the role of social work, highlighting a desire to show a more balanced view, counteracting the risk of being perceived as saying "*anything bad*" about them. However, she goes on to describe her view that, although social work provide helpful support until the child is removed, the support is removed when the child is:

> *"when the child is removed it is literally like 'right that's it', erm the parent is kind of dropped"* (Emma, 239-240).

Her account highlights the tension between trying to be balanced in her view of colleagues and the frustrations she feels on behalf of her clients.

Emotional experiences and attempts to resolve this

Across interviews participants illustrate the lasting emotional impact of working with mothers who have had their children removed. There is a sense from their accounts of trying to strike a balance between gaining experience and managing the distress, but not becoming desensitised. Their accounts suggest an emotional complexity to the role, and the ongoing blurred boundaries.

Emotional impact and empathy: "my world would be destroyed if anybody took my children"

Participants reflected on their experience of the removal process and how they cope with this *"harrowing"* (Dawn, 38) experience. Across interviews, participants illustrated the challenging, emotional impact of the role:

> *"The distress it causes the parents and the distress it causes the child, it was quite hard to live wi' for me"* (Dawn, 25)

Dawn's account of the experience as hard to live with might imply a sense of guilt. She gives an impression of a lasting impact; "a *few that stand out in my mind because of the distress*" (16) and describes how the impact "*stays with us all*" (382), likening it to "*baggage*" (383), which conveys being saddled with something heavy. Her account suggests that certain memories are 'stuck' for her. This is further illustrated in her account:

> *"it was really upsetting… it was absolutely heart-breaking, it was heart-breaking… sorry, I am getting emotional because I still remember it"* (Dawn, 119-121)

Importantly, she apologised to the interviewer, which suggests discomfort over becoming emotional. The idea of staff being impacted emotionally is also highlighted by Libby when asked about training needs. She describes the need for future staff to be prepared:

> *"educate them around what's gonnae happen, what the experiences, what they are maybe going to go through, the trauma"* (Libby, 214-125).

The use of "*trauma*" to describe what staff go through is powerful, and Libby perceives that it "*doesnae get any easier*" (218). Her account suggests an inevitability of the emotional impact for staff, and supports the idea of a long-lasting effect. The complexity and tension in the role are further highlighted by Claire:

> *"it is just so traumatic for them, it is so traumatic for clients. I try to put myself in that position and my world would be* destroyed *if anybody took my children"* (Claire, 357-358).

In endeavouring to empathise with the clients, the imagery and emphasis of her world being "destroyed" is poignant, acknowledging her perception of the huge impact and totality of removal. This process of identifying with the mothers is echoed by Susan:

> *"if I was in their shoes… I would just relate that back to my own child, so that probably the part I found really difficult"* (Susan, 119-120).

Despite describing this level of empathy, participants all reported a need for training around how the mothers feel following removal:

> *"we don't think enough about it in a lot of ways, we don't have enough training for us...about how these women feel*" (Susan, 196-197)

Susan offers an explanation for this perceived lack of understanding, *"maybe we don't even ask them enough"* (198). This is reiterated by Dawn: "*we need to ask the parents*" (441- 442). From their accounts of the removal, it would seem that they do have an understanding of the emotional impact for their clients, yet the participants perceive that they need more training on this. This reinforces the idea of complexity in the role. There is a sense that they perceive a lack of mastery over the emotional aspect of their role and wish for something concrete, like training, to help them.

Complexity within attempts to cope: "I don't mean you become desensitised"

Across narratives, participants describe their attempts to cope with the emotional impact of their role. They convey tension between empathising with the mothers while also trying to maintain a professional role.

> "*You toughen up, I am not saying I don't think about my job when I go home, I do think about my job when I go home" (Claire, 315-316).*

Claire describes a tension between toughening up yet still holding her clients in mind outside of work. Claire appears quick to clarify that, despite becoming more inured to the job, she hasn't lost empathy and still cares and thinks about her work. Dawn similarly articulates tension in her role, describing a removal which was highly distressing and how she tried to manage this by saying to the mother; "*let's start thinking about the future*" (123). She reflected on this pragmatic reaction to distress in her interview and described it as "*avoidance*" (124) on her part, rather than giving due space to the grief and distress. Explaining this, she referred to her perception of her professional role:

> *"I just wanted to absolutely break my heart. As a worker you cannae do that, you've to be the strong person for this person who is crumbling beside you."* (Dawn, 126-127)

The imagery of a client "*crumbling beside you*" conveys fragility, further emphasising the perceived pressure to be strong "*as a worker*". These contrasting images emphasise the conflict between her instinctive reaction to the distress with a perceived obligation to uphold a professional front.

This idea of trying to be stronger and adapting to the emotions associated with removal is reflected in Susan's account, that over time she is "*becoming hardened to it*" (112). This is echoed by Emma's reflections:

> *"I really struggled with it, but I think as time has went on I can hold it as a more holistic picture and really will persevere with things now" (Emma, 79-80).*

The use of the word "*persevere*" suggests an endurance despite her discomfort. Her perception seems to be that by developing an ability to focus on the bigger picture, rather than solely empathising with the mother, she is able to continue her work. This is supported by Dawn's account:

> "*So I think probably you become more confident after every time you deal with that situation, I don't mean you become desensitised, that's a risk… you can become desensitised because you see it constantly, but I think you learn from each experience*..." (Dawn, 178-181)

Dawn's account suggests that she recognises the risk of becoming desensitised by the frequency of child removal, while also recognising the positive aspects of exposure to it in terms of gaining knowledge and confidence. Again, there is a sense of tension or ambiguity in the role, the balancing act between becoming more experienced in dealing with removals and maintaining a sense of empathy for clients.

Discussion

The study aimed to explore the experiences of staff working with mothers who have had their children removed, how they make sense of the systems around them and perceive their training needs. Two superordinate themes were developed: the complexity and tension within working relationships, and the emotional experiences of staff and their attempts to resolve this. While the themes are presented separately, they were inter-related, further highlighting the intricacy of the role.

Through their accounts, participants expressed friction between being part of a system that is involved in child removal while also providing support for mothers. When describing working with the wider MDT, there was a sense of tension and frustration. Participants often highlighted the differences between their work with the mothers and others', and emphasised the incompatibility with other professionals. Through their descriptions it appears that participants responded to the discomfort of being part of removal process by becoming fervent in their role of supporter; actively pursuing the mothers to provide assistance. It would seem from the participants' accounts that the process of removal is highly emotive for

staff, with distressing cases leaving a long-term impression for them. This appeared to be particularly apparent for staff members who had children themselves. Participants offered explanations of how they attempt to cope with this and strike a balance between "toughening up" while still maintaining empathy for their clients.

The findings build on previous research of mothers being traumatised by the removal of their child (Morriss, 2018). Not only do the staff participants reflect on the trauma of removal experienced by the mothers, but they describe finding it traumatic themselves. Evident across participant accounts was an emphasis on tension in their role, and a sense of responsibility over the removal, perceiving blame and experiencing anger directed towards them. They conveyed a lasting emotional impact and guilt, which is consistent with research carried out by Whittaker et al., (2016) into a burden of care for professionals working in this field. They described participants accounts of struggling with support and surveillance of these mothers, similar to the present findings of the duality of being part of the removal process while also providing support.

The concept of dual roles has been well-documented in the field of forensic psychology. Research has highlighted the tension in the role of a forensic psychologist, if they are expected to provide evidence and also develop a therapeutic relationship with the client (Greenberg & Shuman, 2007), similar to the participants in the present study. Interestingly, this research recommends avoiding such a dual relationship, as the two aspects of providing support and potentially damning evidence are in conflict with one another.

The idea of two conflicting aspects of the role was also found in focus-group research with therapists working with parents with substance misuse issues in Norway (Wiig et al., 2018). They found that staff often felt conflicted between rescuing the child and supporting the adults. Their research also demonstrated the emotionally challenging and exhausting aspects of working with parents in these services.

Whittaker et al. (2016) described organisational difficulties of the role, such as IT barriers and the challenge of assessing parenting. Their analysis highlighted ways in which participants described parents who misuse substances, including subthemes of: 'dishonest, damaged and inadequate'. Interestingly, in the present study, parents were not described in such ways. This may be due to how datasets were collected; the Whittaker et al. (2016) study

utilised a focus group whereas the present study involved a one-to-one interview with the team's psychologist. While their study describes the more practical challenges within the role, the present study highlights the emotional impact and the tension inherent in the role.

Comparing the present study with one which focuses on the reunification process, rather than the removal process, there are similarities and differences (Chambers, Crutchfield, Harper, Fatemi & Rodriguez (2018). Chambers and colleagues (2018) also highlight the importance of the working relationship and the persistence of staff to engage with parents early in the process. Key differences include their finding that staff felt they had collaborative relationships with wider team and they felt that families were included in reunification plans.

Limitations

The interviews were carried out in one service in one health board in Scotland, resulting in a potential under-representation of other contexts. This means that the findings may not represent the experiences of practitioners in other areas. Further participant information on age, ethnicity, socio-economic status and parenthood was not recorded for this study. These elements are important to include as they would allow for a greater depth of interpretation and understanding in terms of potential power dynamics; between staff members and mothers, other professionals in the MDT and managers. Future research with samples which include broader representation of different demographics may also allow for a greater insight into differences in experiences between groups. Key characteristics of participants, such as their ethnicity, could potentially impact their narratives and their decision to take part in research in this field. For instance, research has highlighted the barriers to participation of minority ethnic groups in qualitative research, such as stigma and lack of cultural and religious sensitivity (Rooney et al., 2011).

Despite staff being from the same team, the sample was made up of social care workers and addictions nurses, which impacts the homogeneity of the sample. However, there is commonality across all participants in terms of a shared experience of working in addiction services with mothers who have had their children removed.

Interviews were carried out by a clinical psychologist embedded in the team which may have resulted in bias within the findings. Efforts were made to mitigate this, by the interviewer addressing concerns around confidentiality and explaining that no identifiable information will be made available to service managers. Analysis was carried out by a trainee clinical psychologist out-with the team, who completed a reflective log throughout the process and used supervision to discuss assumptions or biases. The sample size was small but analysis was committed to the idiographic nature of IPA, ensuring that in-depth analysis was carried out on each transcript until the researcher was satisfied that saturation was reached and there was no new information discovered. Credibility of analysis was examined by the research supervisor, who checked a number of transcripts and interview summaries to ensure analysis remained rooted in the participants' accounts.

Recruitment bias may have also occurred and it is possible that those who took part may have different experiences to those who chose not to. Staff members who were struggling in their role or are experiencing burn-out may be less likely to take part, particularly as it involved speaking to someone in the team.

The use of IPA allowed the researcher to explore the lived experiences of the participants. The analysis examined the experiences of one particular group, and the researcher acknowledges the need for caution and further research when considering the relevance to experiences of other staff teams. However, the analysis aimed to be transparent and contextualised so that readers can evaluate the level of transferability.

Clinical Implications

Previous research highlighted the lack of research into how staff feel about engaging in this type of work (Cosden, Sanford, Koch & Lepore, 2016). This study demonstrated the complexity of the role and participants were able to reflect on the challenges associated with working in a highly emotional field. The analysis highlighted the ambiguity experienced in the role and how participants attempted to make sense of their role and professional identity. These insights may allow services and wider members of the team, such as clinical psychologists and management, to better understand and provide support to staff members facing these challenges.

The analysis suggests that participants feel a tension and incompatibility with other members of the MDT, such as social work colleagues and management. This is an important finding as research has emphasised the magnitude of positive working relationships in order to provide effective care (Andrews et al., 2018). This highlights the need for services to examine the integration of health and social care further.

A key area that was illustrated throughout accounts was the perceived need for training. Interestingly, participants described a desire for training into the emotional impact for mothers who have had children removed, whilst also articulating their own empathy and understanding of this. They also highlighted a need for new staff embarking on this role to be better informed of the powerful and lasting emotional impact the role is likely to have on them. Therefore, the findings suggest there is a need for training into not only the emotions of the mothers, but also the distress and impact for staff. It is also important that managers consider that the way in which systems are set up can retraumatise service users, and the impact of this on staff such as moral distress and secondary traumatisation (Sweeney, Clement, Filson & Kennedy, 2016). Managers should ensure that adequate supervision and support is provided, so that staff feel that they are valued and that their well-being is important.

The findings of this study highlight the importance of clear implementation and monitoring, using a trauma-informed approach. This can be done via guidance from agencies such as Substance Abuse and Mental Health Services Administration (SAMHSA). In their guidance published in 2014, SAMHSA highlighted key principles to consider when implementing a trauma-informed approach; 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice and choice, and 6) cultural, historical, and gender issues. In Scotland, NHS Education for Scotland (NES) have developed a National Trauma Framework (2017), which acknowledges the spectrum from trauma informed practice to trauma specialist practice level. At each level, psychologists working within teams have a vital role which includes increasing knowledge of trauma and psychological theory, developing formulations to enhance understanding, providing supervision and providing guidance at the leadership level.

This research also illustrated the resilience and determination of the participants in this study. They reflected on the emotional burden of the role but also highlighted the efforts they would

go to in order to reengage mothers. It is important that staff feel supported by management and are protected from burnout. Managers could monitor this is by using a validated measure such as the Secondary Traumatic Stress Scale (STSS) (Bride, Robinson, Yegidis & Figley, 2004).

Future research

The present study captures the accounts of participants working within a certain team with a specific population: mothers who have had their children removed. Future research could expand on this by examining further staff groups in other contexts. In particular, research could seek to recruit staff who have experienced burnout and/or have left the service due to the challenges and emotional impact. Furthermore, research has highlighted the impact of race and culture on the dynamics of the child welfare system, professionals and families (Miller, Cahn & Orellana, 2012). Therefore, it would be important for future research to be designed in a way which is more representative of people from different backgrounds and cultures. This could be achieved by actively involving minority and diverse groups in the research design, implementation and interpretation. It is important that future researchers record demographic information for participants and consider the impact of power and potential discrimination between groups.

Future research could also examine 'grey area' parents, as highlighted by Whittaker and colleagues (2016); parents who would not meet the typical threshold for receiving high levels of support but nonetheless are misusing substances. With increasing cuts and pressure on services it may be that more parents are missed by services, yet the impact on their children may be detrimental. An additional area of interest would be to examine staff who have children themselves. It emerged in this study that participants who had children would reflect upon the removal process with this additional lens, imagining themselves in that position. It would be important to study this experience further.

Conclusions

This study investigated the experiences of staff members working in alcohol and drug recovery services with mothers who have had their children removed. Across their accounts, participants described the complexity and tension inherent in a role where they are both part

of the removal process and the supportive system. Their narratives suggested a sense of determination to fix the situation following a removal, and the challenges of working with other professionals with different priorities. Participants described the often-long-lasting emotional impact of the role and further complexity within their attempts to cope.

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Appendices: Systematic Review

Appendix 1.1 Submission Guidelines for Child Abuse & Neglect Journal

Types of contributions

1. **Research Article**: Child Abuse and Neglect publishes quantitative, qualitative, and mixed-method research. Particular focus will be placed on thorough and appropriate methods, strong data analysis and discussion of implications for the field.

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Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2010). The art of writing a scientific article. *Journal of Scientific Communications, 163*, 51–59.

Reference to a book:

Strunk, W., Jr., & White, E. B. (2000). *The elements of style.* (4th ed.). New York, NY: Longman.

Reference to a chapter in an edited book:

Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281–304). New York, NY: E-Publishing.

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All necessary files have been uploaded, and contain:

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Further considerations

• Manuscript has been 'spell-checked' and 'grammar-checked'

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• All references mentioned in the Reference list are cited in the text, and vice versa

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Appendix 1.2: CINAHL search

#	Query	Limiters/Expanders	Last Run Via	Results
S11	S3 AND S5 AND S10	Limiters - Published Date: 20110601-20210104; Language: English Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	166
S10	S8 OR S9	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	744,948
S9	(MH "Parental Behavior") OR (MH "Parent-Child Relations+") OR (MH "Parental Attitudes+") OR "outcome* or rehab* or retention or 'parenting stress' or 'parent-child interaction*' or engagement"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	53,537
S8	S6 OR S7	Expanders - Apply equivalent subjects	Interface - EBSCOhost	728,612

		Search modes - Boolean/Phrase	Research Databases Search Screen - Advanced Search Database - CINAHL	
S7	MH "Parental Behavior") OR (MH "Parent-Child Relations+") OR (MH "Early Intervention") OR "'child welfare interventions' or 'parent-child interventions' or treatment or 'integrated treatment program*' or 'parent* intervention' or 'parenting skills' or 'parent* training'"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	49,341
S6	(MH "Early Intervention") OR (MH "Substance Use Rehabilitation Programs") OR (MH "Drug Rehabilitation Programs") OR (MH "Alcohol Rehabilitation Programs") OR ("therapeutic")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	693,129

S5	S3 AND S4	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	689
S4	MH "Mother-Infant Relations") OR (MH "Expectant Mothers") OR (MH "Mothers") OR "mother*"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	106,693
S3	S1 OR S2	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	28,970
S2	(MH "Substance Use Disorders/PC/PF") OR ""substance abus*" or "drug abus*" or "alcohol abus*" or "problematic substance use" or "substance use disorder*" or "addic*"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	28,535

	or "substance misus*" or "alcoholism"" OR (MH "Substance Abusers") OR (MH "Alcohol Abuse+")			
S1	(MH "addiction*")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	522

Appendix 1.3: Quality Assessment tool (EPHPP)

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely
2 Somewhat likely
3 Not likely
4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80 - 100% agreement
2 60 – 79% agreement
3 less than 60% agreement
4 Not applicable
5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial
2 Controlled clinical trial
3 Cohort analytic (two group pre + post)
4 Case-control
5 Cohort (one group pre + post (before and after))
6 Interrupted time series
7 Other specify _____
8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

1

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

1 Yes
2 No
3 Can't tell

The following are examples of confounders:

1 Race
2 Sex
3 Marital status/family
4 Age
5 SES (income or class)
6 Education
7 Health status
8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

1 80 – 100% (most)
2 60 – 79% (some)
3 Less than 60% (few or none)
4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes
2 No
3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

1 Yes
2 No
3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes
2 No
3 Can't tell
4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell
5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell

(Q2) Was the consistency of the intervention measured?

1 Yes
2 No
3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

4 Yes
5 No
6 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)

community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?

1 Yes
2 No
3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

1 Yes
2 No
3 Can't tell

GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**SELECTION BIAS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
B	**STUDY DESIGN**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
C	**CONFOUNDERS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
D	**BLINDING**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
E	**DATA COLLECTION METHOD**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
F	**WITHDRAWALS AND DROPOUTS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes

If yes, indicate the reason for the discrepancy

1	Oversight
2	Differences in interpretation of criteria
3	Differences in interpretation of study

Final decision of both reviewers (circle one):

1	**STRONG**
2	**MODERATE**
3	**WEAK**

Appendix 1.4: Data Extraction Tool

Authors:

Year:

Title:

Country:

Study Aims:

Design:

Intervention:

Setting:

Inclusion/exclusion:

Participants:

- Age
- Age of child
- Ethnicity
- No. of children
- Employment status
- Educational attainment
- Marital status

Measures:

Results (stats, effect sizes):

Main findings:

Quality rating:

Appendix 1.5: Participant Characteristics

Table 1: Participant Characteristics

Studies	Mother age	Child age (months)	Ethnicity	No. of children	Employment status	Educational attainment	Marital status
Gannon et al. (2017)	30.63 (4.27)	14.89 (14.02)	Caucasian = 76.2% African American =7.0% Multi = 7.7% Hispanic = 9.2% Non-Hispanic = 88.7%	2.75 (1.89)	Employed = 8.6%	8th grade or less = 4.2% Some HS = 26.8% HS = 29.6% Some college = 4.2% College = 4.2%	Single = 45.4% Partner = 43.3% Married = 5%
Hildebrandt et al. (2020)	27.5 (6.1) range 18-42	10.7 (5.2) range = 3.7 – 20.8	Caucasian = 75.4% African American = 3.5% American Indian/Alaskan native = 7.0% Asian = 3.5%	2.7 (1.3, range = 1-6)	Not reported	Mean years= 11 (SD = 1.7, range 8-16)	Married/living as married = 7.0%

Jeong et al. (2015)	29.5 (5.49), range (20-40)	15.66 (15.55), range = 1-60	Not reported	Not reported	Employed = 4%	Completed HS = 50%	Not reported
Porter et al. (2015)	27.8 (range 18-42)	Mean not reported (range 1-4)	White = 40.6% Asian = 2.2% Black = 37.0% Hispanic= 16.7% Native American = 2.2% Other = 1.4%	1 child = 27.5% 2= 24.6 3= 16.7% 4= 17.5 ≥ 5 = 12.0%	Not reported	0-6 years = 3.6% 7-12 = 78.3% Tech/ vocational college = 2.9%	Single = 77.5% Married = 9.4% Divorced/ widowed = 13.0%
Suchman et al. (2012)	30.21 (6.39, range 19-42)	18.54 (12.27, range= 1-36)	Caucasian = 70.8% African American = 20.8% Hispanic = 8.3%	2.04 (1.30, range = 1-6)	Employed =13%	Mean years = 12.21 (1.32)	Never married = 33.3% Cohabiting = 33.3% Married = 16.7% Separated/ divorced = 16.7%

Suchman et al. (2017)	29.66 (5.42)	27.64 (14.86)	Caucasian = 77.25% Hispanic/ Latino = 3.4% African American = 13.7% Other = 5.7%	Not reported	Employed = 20.0%	Years = 12.37 (2.13)	Never married = 43.1% Cohabitating = 32.5% Divorced/separated = 13.5% Married = 13.5%
Suchman et al. (2018)	29.9 (5.29)	27.9 (14.88)	Caucasian = 78.6% African American = 13.1% Hispanic/ Latina = 3.5% Other 4.8%	1.67 (0.99)	Employed = 20%	Years = 12.44 (2.18)	Never married = 40.5% Cohabitating = 35.7% Divorced/separated = 9.5% Married = 14.3%

Appendix 1.6: Outcome Measures - Additional Information

Table 2: Outcome measures: additional information

Measure	Type	Brief overview
1. The Keys to Interactive Parenting Scale (KIPS). (Used by Gannon et al., 2017)	Observation	Validated tool sensitive to changes in parenting quality in families – including those with substance use (Comfort and Gordon, 2010). Children aged 2 months – 5 years old. 20-minute observation Three subscales are scored, ‘‘building relationships,’’ ‘‘promoting learning,’’ and ‘‘supporting confidence.’’ The interrater reliability was found to be Kappa = 0.93 ($P < 0.001$).
2. The Functional Emotional assessment scale (FEAS)	Observation	Validated, observation-based Children 7 months – 4 years

(Used by Hildebrandt 2020)		Normed for typical and 'multi-problem' families Subscales: (1) self-regulation and interest in the world; (2) forming relationships, attachment, and engagement; (3) two-way, purposeful, communication; and (4) behavioural organisation, problem solving, and internalisation.
3. The Adolescent–Adult Parenting Inventory–2 (AAPI–2) (Used by Jeong, 2015)	Questionnaire	40-item questionnaire Examines the parenting-related attitudes of adolescent and adult parents Subscales: (a) inappropriate parental expectations of their children, (b) parental lack of empathy toward their children's needs, and (c) role-reversal in parent–child relationships.
4. National Longitudinal Survey of Children and Youth (NLSCY) (used by Jeong et al, 2015)	Questionnaire	Child Questionnaire items Frequencies of parent-child interactions,

		frequencies of developmentally appropriate and play-based interactions with their children Versions for 0-2 years old, and 3 - 6 years old
5. Observation Checklist on Mother-Infant Interaction (OMII) (used by Porter et al., 2015)	Observation	Developed with SU mothers A free-play and separation-reunion paradigm Developed with 12-month-old infants Computerised coding system Examines; verbal, educational, visual monitoring, and structuring behaviour of the mother, indications of warmth and negative affect toward her child. 95% overall interrater reliability
6. The Parent Development Interview (PDI) Aber, Slade, Berger, Bresgi & Kaplan, 1985)	Interview	1-hr semi structured interview focusing on mother's capacity to mentalise about her own, and her child's behaviour.

(used by Suchman, 2012, 2017, 2018)		Mentalisation focused: examines ability to think of internal experiences during interactions. child's behavior, thoughts, and feelings in various situations, as well as her responses to her or his child in these situations. 1. parent's representation of the child, 2. Parent's representation of the relationship, and 3. Parent's capacity for mentalization, particularly in moments of high intensity affect. Coding methods Interclass correlations ≥50 for each item on 15 independently rated protocols
7. The Working Model of the Child Interview (WMCI) (used by Suchman et al., 2012, 2017, 2018)	Interview	Mental representations of the child Assesses the quality of mother's representation of the child and the relationship. 1.5 hour semi-structed interview

		0-5 years old Interclass correlations ≥.50 for items on 15 independently rated protocols. Characteristics – richness (knowing child), openness, coherence, caregiving sensitivity, acceptance and intensity of involvement.
8. The Nursing Child Assessment Satellite Training Teaching Scale (NCAST) (used by Suchman et al., 2012)	Observation	73 binary-item observation tool. 0-3 years old 90% reliability Subscales: Sensitivity to cues, response to distress, social-emotional growth fostering and cognitive growth fostering.
9. Caregiver sensitivity Curiosity Box Paradigm (CBP) (used by Suchman et al, 2017, 2018)	Observation	Observational tool The mother and child explored a box with 12 toys (familiar and scary). Coded using Coding Interactive Behaviour system (CIB; Feldman, 1998)

		CIB Maternal sensitivity – responsiveness, positivity, affection, support, encouragement, and warmth. Specific codes – 1) Acknowledging, 2) Parent Gaze/Joint Attention, 3) Positive Affect, 4) Vocal Appropriateness, Clarity, 5) Appropriate Range of Affect, 6) Consistency of Style, 7) Resourcefulness, 8) Parent Supportive Presence, and 9) Adaptation-Regulation Well-established tool – validated across ages, cultures and with high and low risk dyads (Feldman, 2010; Feldman, Eidelman, & Rotenberg, 2004; Feldman & Klein, 2003; Feldman & Masalha, 2010) Maternal Sensitivity Scale composite scale (Cronbach's α = 0.93) Interclass correlations for the 12 items ranged from 0.77 (p b 0.05) to 0.99 (p b 0.001).

Appendices: Major Research Project

Appendix 2.1: Ethics Documents

Change to study team

NHS Greater Glasgow and Clyde

R&D/IRAS Reference	GN17MH627/211262
Study short title	Mothers in Addiction Services who have had their children removed
Site* in NHS GG&C	North West Glasgow Alcohol and Drug Recovery Services

A. Please confirm below (part a) any details of new researchers being added to the study.

B. Also detail at part b – any change of principal investigator information.

A. Researcher name	**WTE hours***	**Do they have a contract with the NHS?**	**Research activities**	**Employer**	**Are they replacing someone? (if so, who?)**
Sarah McFarline	0.4	Yes	Analysis and write up of staff interviews as part of larger study	NHS Highland	No
Naomi White	0.1	No	Academic supervision of Sarah McFarline's analysis and write up of staff interviews	University of Glasgow (Doctorate in Clinical Psychology Programme)	No
B. Is there a change of PI?					

**WTE hours – Confirm here how many hours per week the researcher will be working on the study*

Declaration by PI or Local Collaborator (by sending the above info by email, you are agreeing to the following as PI)

- The information in this form is accurate to the best of my knowledge.
- I am aware of and have agreed to discharge my responsibilities in line with the UK Policy Framework for Research and Social Care.
- I have considered and mitigated any conflicts of interest that I may have.

Email:

From: O'Neill, Elaine <Elaine.O'Neill2@ggc.scot.nhs.uk>

Sent: 19 May 2020 09:07

To: Lynda Russell <Lynda.Russell@glasgow.ac.uk>

Cc: Emma-Jane Gault <EmmaJane.Gault@glasgow.ac.uk>

Subject: R&D Ref GN17MH627 Protocol v4.0 NSA02 (13/05/20)

Dear Dr L Russell,

Governance checks for this amendment are now fully concluded. However, while contingency arrangements are in place for COVID19 you are NOT permitted to initiate or recruit to this trial. As soon as the temporary Board-wide recruitment suspension has been lifted you will be notified that recruitment can commence/recommence. We apologise for any inconvenience.

R&D Ref: GN17MH627 **Ethics Ref**: GN17MH627

Investigator and site(s): Dr Lynda Russell (Glasgow Addiction Services)

Project Title: Study to investigate the feasibility of developing a psychological intervention to support mothers within NHS Addiction Services who have had their children removed

Protocol Number: V4.0 13/12/17

Amendment: Non-substantial Amendment 2 (13/05/20)

Sponsor: NHS Greater Glasgow and Clyde

I am pleased to inform you that R&D have reviewed the above study's Amendment and can confirm that Management Approval is still valid for this study.

Non-substantial amendment documents reviewed:	Version	Dated
Notice of minor amendment form		13.05.20
Change of study team form		11.05.20
Sarah McFarline CV		

I wish you every success with this research project.

Kind regards

NHS GG&C R&D
Ward 11 Dykebar Hospital
Grahamston Road
Paisley PA2 7DE

Web: www.nhsggc.org.uk/r&d

Appendix 2.2: Interview schedule (Version 1 01/10/2017)

Interview schedule – staff

How long have you worked in Addictions Services?

How many mothers have you worked with who have had their children removed?

Can you tell me about your experience of working with mothers within Addiction Services who have had their children removed?

Has your practice changed over time? Why?

What have you found helps or works well for this group of women?

What do you find doesn't help or work as well with these mothers?

Have you had any training about working with this group of women?

Based on your experience, if we were to design training for addiction staff what would this training need to cover?

What do you think we need to do or provide within Addiction Services to support these mothers?

Appendix 2.3: Transcript Except & Transcript Summary

	70		a lot more drugs and just going total kind of like binges and things like that. So, aye,
	71		difficult. (laugh)
	72	I	Do you think your practice has changed over time?
Worker trying to cope with that by holding in mind child. Cope with the guilt. "never forget" – long lasting emotional impact "Part of that" - Feeling that it was her fault child was removed? Persevere now – attempts to manage Change over time.	73	P	I don't think my practice has changed, but I think my mind-set has changed a bit. Erm when
	74		I first worked in addictions, the very first, I will never forget the first case that I worked with
	75		and the child was removed. I felt, although I totally seen from the social work point of view
	76		and the child was safe, I felt really guilty because I'd this good relationship with this client
	77		erm and then I felt like I was really part of that child being removed and I was because I
	78		kept highlighting to social work and things like that, the concerns. Erm ((pause)) so I found
	79		that…I really struggled with it, but I think as time has went on I can hold it as a more
	80		holistic picture and really will persevere with things now. I felt that I have got a better
	81		grasp on things and like noticing when there are concerns with certain behaviours from
	82		clients. So I don't think my practice has may be changed so much…erm well maybe I
	83		suppose actually in terms of like doing things like just things like ad-hoc visits…I would have
	84		done them before but now I see the value more in things like that, but I suppose that's
	85		more…that's not really supporting the client that's more for the child and erm…
	86	I	How do you balance that relationship between the child's needs and your client's needs?
Contrast with social work?	87	P	It is hard to balance that because you don't…social workers are working for the child and
	88		obviously child protection is everyone's business and all that kinda thing, but that's what I

Bold – Linguistic
Italic – Descriptive
Red – Conceptual
Underlined - emphasised speech

5

"Kind of like binges" matter of fact?

Laughter – discomfort?

Mindset change – how she views, copes?

"I will never forget" - powerful

First case

"Really guilty" - emotion

Part of child being removed

"Really struggled"

"Persevere" – continue despite difficulty, holistic picture helps her to cope?

"Better grasp" – better mastery, confidence?

"Certain behaviours" – tentative?

"Hard balance"

"All that kinda thing" – dismissive? Aloof? Causal?

Feeling torn – between support and reporting, duality of role.

Contrast with social work

Duality of role – clients forget the two sides.

Being direct – "get things together"

find really hard because we say to clients 'we are here to support you and it is all about you and we want to support <u>you</u>', but then when they are honest about things it is like 'oh right we need to report that'. So I can understand why they find it difficult to tell us certain things, but I do find it hard to keep that balance. I just try and be transparent with erm patients as well and kind of say 'well this is …I am concerned about this and I have to report this', erm and I am surprised actually social workers say that quite often …I've seen it myself in meetings, like you go in and the client is not actually aware of …because you have got that relationship with them, I think they forget, you know…they understand that you have got concerns but when it is in a meeting like that and in that intense environment and you are voicing all those concerns, sometimes the client isn't quite as aware of the level of your concern. So that's probably something that I've actually changed as I make sure that I am always transparent, especially before meetings, discuss the report that I've created just to explain to them. I think actually I am more like brutal with them in the sense that I've …previously I would have been …I would have sugar-coated things whereas now I will say like 'your children will be removed erm ….', just to try and frighten them (laugh) a bit as well and let them know how serious things are, but I will say 'this is your chance to get things together, if you do your child will probably be returned and if not they will be removed….' I am more confident in saying that now whereas before I would have may be put it onto social worker a wee bit like 'well we will see what happens…', whereas now I feel more confident in being direct about it.

I Okay, why do you think those changes came about?

"Find really hard"

Emphasising support

Conflict – between supporting them and reporting them? **"balance"**

"Transparent"

Intense environment – intense for worker too

"Voicing all this concerns" how does that feel for worker? Like a betrayal?

"Transparent"

"Brutal" &

"Sugar-coated" - contrast

Is she finding it uncomfortable talking about being brutal?

Wants to be direct, frighten women, steer them in the right direction?

Confidence

"Direct"

Bold – Linguistic
Italic – Descriptive
Red – Conceptual
<u>Underlined</u> - emphasised speech

Transcript Summary:

T2: "Dawn"

It seems there are a few mothers and their stories that stand out for Dawn. She explains this is because of the level of distress. When she describes these stories there is a lot of emotion, such as the "horrendous trauma" (41) and describing the mother as "frail" emotionally and physically (47). There is a sense of a strong connection with this mother, and Dawn depicts trust and a sense of privilege at being asked to record the mother's last interaction with her child:

> "*that whole hour was just an absolute… it was a joy to see…it was a joy to be in the room*" (116-117)

The language used to describe this interaction is very powerful and positive and then there is a shift when the child "was actually taken away" (120). This shift highlights the complexity of the role. She described this as heart-breaking and there seems to be a parallel process where the mum "managed to contain herself" and hide emotions from child (119-120) and Dawn had to "be the strong person" (126) and not show her emotions to the mother. This appears throughout – the idea that as a "worker" (126, 21, 25) she needs to be strong:

> "you've to be the strong person *for this person who is crumbling beside you*" (126-127)

> "*I don't like not being able to support people*". (151-152)

There is a sense of discomfort and powerlessness when Dawn is unable to support these mothers .

> *"I was very much in the dark (109)"*
> *"oh God what do we do?* (110-111)"

> *"…so I feel really frustrated and quite, what's the word… erm…powerless to help her*" (290-291)

In order to cope with this Dawn tries to be open and honest with the mothers she works with and focuses on plans with them. It may be that this provides her, and perhaps the mothers, with a sense of control in what seems to be a complex and powerless situation.

"*I just sat with her saying 'look we need to think about where you are going to go from here, what are your plans for the rest of the day?'… then I was happy to leave her, because she had a plan for that day*" (133-137).

She explained that this response was a way for her to cope with the situation:

> *"So it was me I was trying to do avoidance and blah, blah, blah" (124).*

It seems that Dawn has a desire to label the process of child removal, using a grief model but struggles with that not entirely capturing the experience for mothers. Again it seems that she is hoping for a sense of mastery and an understanding of what tools are required.

> "*it is a* different *thing, it's two, well I see it as two different things*" (145-146)

> …"*you knew what you were dealing with, you knew it was actual grief caused through the death of a baby… there is training there for that, you know what to do*" (496-499).

Dawn describes how she sees the situation for the mother following the removal:

> *"everybody withdraws from the parents and it's* awful *they get a terrible service. ((quieter)) They withdraw as well" (189-190)*

There is a sense of frustration and sadness in her account, and she emphasises awful and is quieter when talking about the mothers withdrawing. She tries to be balanced with talking about the MDT, explaining that is it "just my personal opinion" (252)

Dawn's account is highly emotive and she describes a few instances which seem poignant to her and have had a lasting impact. She articulates the complexity of the role, striking a balance between showing empathy and being strong for her clients. She also describes the difficulty of managing the emotions associated with removal and the ways in which she attempts to cope. This includes trying to focus on plans with mother and trying to label and understand removal as a loss, similar to bereavement. There is a sense that she would like to understand the impact of removal on mothers in order to better support them.

Appendix 2.4: COREQ checklist

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	39
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	41
Occupation	3	What was their occupation at the time of the study?	41
Gender	4	Was the researcher male or female?	41
Experience and training	5	What experience or training did the researcher have?	41
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	41
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	41
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	39
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	38
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	39
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	39
Sample size	12	How many participants were in the study?	39-40
Non-participation	13	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	39
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	39
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	40
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	39
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	39
Field notes	20	Were field notes made during and/or after the inter view or focus group?	N/A
Duration	21	What was the duration of the inter views or focus group?	39
Data saturation	22	Was data saturation discussed?	54
Transcripts returned	23	Were transcripts returned to participants for comment and/or	N/A

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	41
Description of the coding tree	25	Did authors provide a description of the coding tree?	N/A
Derivation of themes	26	Were themes identified in advance or derived from the data?	40-41
Software	27	What software, if applicable, was used to manage the data?	N/A
Participant checking	28	Did participants provide feedback on the findings?	N/A
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	41
Data and findings consistent	30	Was there consistency between the data presented and the findings?	41-52
Clarity of major themes	31	Were major themes clearly presented in the findings?	41-52
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	41-52

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Appendix 2.5: MRP Proposal

DOCTORATE IN CLINICAL PSYCHOLOGY: MRP PROPOSAL

Matriculation Number: 2356263
Name of Assessment: MRP Proposal

Title of Project: The Experience of Staff Working with Mothers in Addiction Services who have had their Children Removed.

Date of Submission: 25/10/20

Version Number: 3

Word Count: 3,039

Abstract

Background

Studies have found high levels of trauma, poverty and domestic abuse (Mandavia, Robinson, Resslet & Power, 2016) for mothers who misuse substances. Successful treatment of substance abuse relies on these women gaining support, in particular having the opportunity to develop relationships with the staff who support them. Previous research has demonstrated the impact working in this field can have on staff, including high staff turnover, vicarious trauma and burnout (Chen & Scannapieco, 2010).

Aims

This study will explore the experience of staff members working with mothers who have had their children removed and how they make sense of their experiences.

Methods

A qualitive approach will be used with secondary data, which was gathered as part of a separate study. This data will be analysed using Interpretive Phenomenological Analysis (IPA).

Application

This research aims to make sense of how staff understand and discuss their experiences of working with mothers who have had their children removed. It is hoped that this information can be used to better support staff working in this area, and may be used to help develop training.

Introduction

Substance misuse among mothers is a serious issue for parenting and poses a significant burden to society. According to the Children's Social Work Statistics Scotland (2018-2019, Scottish Government), 16,068 children were looked after or on the Child Protection register in Scotland. Parental substance abuse was identified as a concern in 1,061 of case conferences, with similar figures to domestic abuse and neglect. In the period 2016-17, 2,954 women were on the Scottish Drug Misuse Database (Information Service Division (ISD) & National Statistics, 2018) and a further 3,815 were on the Drug and Alcohol Waiting Times database.

Research has demonstrated that substance misuse in mothers is associated with parenting difficulties and risk of child maltreatment (Kelley et al., 2015). These mothers may be limited in their ability to respond effectively to their child's needs (Pajulo, Suchman, Kalland & Mayes, 2006). Studies have also highlighted the needs of these mothers, demonstrating that there are often associated issues such as complex trauma, mental health difficulties, poverty and experiences of domestic abuse (Mandavia, Robinson, Resslet & Power, 2016). It can be argued that women in addiction services who have had their children removed may be additionally traumatised by the removal of their child, experiencing a traumatic loss, shame and stigma at being a 'flawed mother' (Morriss, 2018).

In order to meet these complex needs, research has highlighted the importance of care which is multi-sectoral, integrated (Andrews et al., 2018) and trauma-informed (Farley, Golding, Young, Mulligan & Minkoff, 2004; Douglas, et al., 2010). Andrews and colleagues (2018) also highlight the importance of relationships – between mother and service provider, among staff, between staff and management and between community partners. These relationships are seen as crucial for effective service delivery.

Unfortunately, there are difficulties associated with working in this field that can make it difficult to provide the most effective service. Whittaker et al., (2016) found that professionals report a burden of care, and anxiety over their sense of responsibility working with this population. At the higher system level, there can be barriers to providing good care, including declining resources (Whittaker et al., 2016), restrictions on service delivery and the complexity involved in providing a service to a population with high relapse rates and comorbid mental health difficulties (Festinger, Rubenstein, Marlowe, & Platt, 2001; McGovern, Xie, Segal, Siembab, & Drake, 2006). These pressures can filter down to the staff level, which can lead to burnout and high turnover (Chen & Scannapieco, 2010).

Being part of a process that involves child-removal and providing support to vulnerable mothers is likely to be highly emotive for staff and there is a lack of research into how staff feel about engaging in this type of work (Cosden, Sanford, Koch & Lepore, 2016). Workers may feel uncomfortable with trauma-informed practice, with trepidation centred around a lack of training, fear about making things worse and not having the time (Kunins, Gilbert, Whyte, Meissner & Zachary, 2007). Previous studies have highlighted the risk of staff developing vicarious trauma (Bride, Hatcher & Humble, 2009; Bride & Kintzle, 2011; Elwood, Mott, Lohr

& Galovski, 2011; Green et al., 2011). Vicarious trauma is a psychological response that can develop as a result of engaging empathically with clients who have been exposed to trauma. Signs of vicarious trauma can range from a reduction of empathy towards clients to symptoms associated with post-traumatic stress Disorder (PTSD). There is also the potential for positive outcomes, such as post-traumatic growth (PTG) in this area for staff who have experienced trauma (Cosden et al., 2016). Definitions of PTG, which is also known as adversarial growth, include a greater appreciation of life and improved relationships and increased spirituality (Calhoun & Tedeschi, 2013).

It is clear from the literature that this is a complex area of study, with research highlighting the demands on services and staff to provide effective support to mothers who have had their children removed. Studies have highlighted the impact trauma-focused work can have on staff generally, but there is a lack of research with staff working in addiction services (Huggard, Law and Newcombe, 2017). Research has demonstrated the importance of the staff-client relationship but further research should be carried out to examine staff members' experiences of this relationship. In particular, there is a limited research looking at the lived experience of staff working with mothers who have had their children removed and the impact removal has on them, the relationship with the mother and the service as a whole.

Aims

The current study is guided by the following questions:

- How do staff members experience working with mothers who have had their children removed?
- How do staff make sense of the wider system around them, such as multi-disciplinary team working, and their role within this?
- How do staff understand and report the challenges associated with this role and how do they perceive their training needs?

Plan of Investigation

Data Source and Approvals

The data to be analysed in the present study were originally collected as part of a separate study, which examined women in addiction services who have had their children removed.

The description of the participants, materials and procedures that follows below relates to the original study. Approval for use of the data in the present study was granted via an amendment to the original study (R&D ref GN17MH627; amendment approved on 19/05/20).

Participants

Participants recruited for this study were staff working in an Alcohol and Drug Recovery service in Glasgow. There were 6 participants in total, each taking part in a one-off interview.

Inclusion criteria

- Over 18 years of age
- Male or female
- Fluent in English
- Current staff members of an Alcohol and Drug Recovery Service (i.e. social care worker, nurse, medic, pharmacist)
- Have worked with women who have had a child or children removed from their care.

Exclusion criteria

- Under 18 years of age
- No longer work for the service
- No experience of working with women who have had a child or children removed from their care.

Recruitment

Staff were made aware of the study through their team leads and provided with information from the chief investigator during team meetings. Staff who were interested in taking part in the study could then contact the chief investigator directly.

Measures

The secondary data which will be used in this study is from semi-structured interviews of staff members. These interviews lasted approximately one hour (Range 20 – 72 minutes, Average 44 minutes). The original researcher developed a semi-structured interview schedule (Appendix 1) following discussion with service users.

Design

This study will involve secondary analysis of qualitative data, using Interpretive Phenomenological Analysis (IPA) to explore how staff report their experience of working with mothers who have had their children removed. IPA is theoretically underpinned by phenomenology, hermeneutics and idiography (Pietkiewicz & Smith, 2014). Phenomenology is concerned with the way things appear to participants in their experiences and the essential aspects of the experiences which make them unique. Hermeneutics is concerned with the mindset of the participant and the language they use, and researchers attempt to understand as much as possible what it is like to be this person and use interpretation to make sense of the individual's world. Finally, ideography involves the in-depth analysis of single cases before making any general comments. In other words, IPA will allow the researcher to examine and seek insight into the participants' experiences, how they make sense of their experiences while acknowledging the impact of the researcher's own interpretation of this (Smith & Osborn, 2015).

Data Analysis

Interpretive Phenomenological Analysis (IPA, Smith, Flowers & Larkin, 2009) will be used for this study. Data analysis will follow a 6-step process outlined in Smith et al. (2009). These steps include (1) reading and re-reading; (2) initial noting; (3) developing emergent themes; (4) searching for connections across emergent themes; (5) moving to the next case; and (6) looking for patterns across cases. Each step is discussed below.

During stage one, the first interview transcript for participant one will be read while the audio recording is played. In order for the researcher to become fully immersed in the data, this process of re-reading the transcript and re-listening to the audio will continue until sufficient familiarisation is achieved before proceeding to the next stage.

In stage two the transcript will be coded line by line, noting words or phrases of interest to developing an understanding of that participant's narrative of working in this field. Once all transcripts are coded with the initial notations, these notes will be used to develop emergent themes. The emergent themes will then be organised into broader categories of meaning, called super-ordinate themes. During the final step of analysis, super-ordinate themes and their corresponding emergent themes for each case will be compared and connections can be explored.

Rigour

A number of steps will be taken to ensure rigour during data analysis. Firstly, in addition to the primary researcher, the academic supervisor will read two transcripts and the associated emergent themes, allowing interpretations to be discussed. Alongside this, a research diary will be used for the duration of the study. This will allow for an acknowledgment or 'bracketing off' (Smith et al., 2009) the researcher's assumptions and preconceptions. The research diary will also serve to encapsulate the decision-making process during the development of themes. The study will also use the consolidated criteria for reporting qualitative research (COREQ) checklist (Tong, Sainsbury & Craig, 2007). The researcher will also develop a summary for each interview to help the analysis to remain grounded in the participant's narrative.

Reflexivity

Data will be analysed by a trainee clinical psychologist with experience working with staff teams, which will allow an informed perspective on the interviews. The participants are not known to the researcher and the researcher has not worked in the addiction service. The researcher will discuss any known assumptions or biases prior to data analysis in supervision. The researcher will adopt a reflective stance, ensuring that there is transparency and to manage expectations that can come from reviewing the literature. The researcher will keep a reflective diary, documenting the interpretive process and the relationship between the researcher, the data and their personal understanding of what it might mean for staff to work in this context. An important aspect of IPA is the explicit acknowledgement that the analytical process involves the researcher attempting to understand how others make sense of their experience.

Justification of sample size

According to the philosophy of IPA, Smith et al. (2009) argue that sample should be small to allow for sufficient idiographic analysis. The recommended sample for a doctoral level thesis using IPA is between 4-10 participants (Pietkiewicz & Smith, 2014). The sample size for the present study is 14 participants (average interview duration 44 minutes, range 20 – 72 minutes).

Settings and Equipment

Interviews were carried out by the original researcher at an Alcohol and Drug recovery service in Glasgow.

Health and Safety Issues

As the researcher will be analysing secondary data there is no risk of harm. The recordings are likely to include distressing information and the researcher will use supervision appropriately for support with this.

Ethical Issues

The original researcher was the team psychologist, and staff interviews were carried out with their colleagues. The original research addressed potential concerns around confidentiality by making it clear to participants that no identifiable information would be shared with service managers. The researcher for the present study does not work in the service, which may help to reduce bias in the analysis.

Data will be handled following GDPR guidance (2018), local Good Clinical Practice (2017) and local data governance guidelines. Anonymised transcripts and interview recordings will be made available to the researcher via a restricted access shared drive on a secure University of Glasgow server, which will be password protected.

Original recordings will not be stored on the researcher's computer. Anonymised transcriptions will be stored in an encrypted folder on a password protected laptop.

Timeline

	MRP
Oct 20	26/10 Send full MRP-P to RO'C & NW
Nov 20	9/11 Sv/ Research Progress Mtg ?tbc Begin Data analysis and write up 20/11 Send (23/11 NW to review) Draft Initial analysis: Transcript 1 25/11 3.15 Sv mtg
Dec 20	7/12 9am Sv mtg 7/12 Study week 11/12 Send (14/12 NW to review) Draft Results 16/12 3.15pm Sv

	18/12 Send (21/12 NW to review) Draft Discussion
Jan 21	8/1 send (11/1 NW to review) first Full Draft of MRP chapter 29/1 send (1/2 NW to review) final Draft of MRP chapter
Feb 21	**Submission 26th Feb**
Mar 21	Viva prep: mock viva / Sv mtg TBC
Apr 21	**VIVA**

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Appendix 2.6: Original MRP Proposal

Matriculation Number: 2356263
Name of Assessment: MRP Proposal

Title of Project: The Challenges Associated with Paediatric Oncology Treatment for Rural Families: A Dyadic Study.

Academic Supervisor: Dr. Naomi White

Field Supervisor: Dr. Stephanie Bannon

Date of Submission: 09/08/19

Version Number: 6 (following Blind Review)

Word Count: 3, 258

Abstract

Background

Survivorship rates for children and young people (CYP) have now reached 82% across all cancers (Children with Cancer UK, 2019). Increasing numbers of survivors mean that there is an increased need for research to examine the transition period following the acute phase of treatment. Previous research has shown that cancer causes high levels of distress for all members of the family system (Houtzager, Grootenhuis & Last, 1999). There can be extra burden on these families if they are required to travel long distances to receive treatment (NICE, 2005).

Aims

The aims of this study are to examine the transition period following the acute phase of treatment for families living in the Highlands who are required to travel a long distance (100-200 miles) for treatment.

Methods

Separate, semi-structured interviews will be conducted with adolescents (10-19 years old) and their primary caregiver. Data will be analysed using the Framework approach utilising dyadic analysis to compare narratives within and across dyads.

Application

The project will examine the experience of adolescents and their parent/carer from remote and rural areas during the transition period following cancer treatment. This will provide rich information for clinical teams working with this population, highlighting improvements that can be made.

Introduction

Around 1,800 children are diagnosed with cancer each year in the UK (Cancer Research UK, 2019). Survival rates have improved dramatically over the past few decades, with an average survival rate of 82% across all childhood cancers. It is estimated that 35,000 survivors of childhood cancer live in the UK, increasing by 1,300 per year (Children with Cancer UK,

2019). Due to improvements in survivorship, it is important for research to examine the impact of cancer and how these young people experience the transition period following treatment.

Previous research has demonstrated that childhood cancer causes a great deal of distress for the child and all members of their family unit (Houtzager, Grootenhuis & Last, 1999). Alongside the life-threatening nature of cancer are a range of symptoms including lethargy, insomnia, and pain (Collins et al., 2002). Understandably, children develop major concerns about changes in their physical ability, appearance, and mood (Freeman, O'Dell & Meola, 2003) and these changes can weaken a child's sense of self (Woodgate, 2001). Symptoms can cause a great deal of suffering for families, impacting on their sense of normality and cause them to feel powerless (McGrath, 2001).

Research has found elevated levels of stress relating to the parent-child relationship (Pinquart, 2018) and links between parenting stress and; anxiety and depression in children and parents (Fonseca, Nazaré, & Canavarro, 2011), impaired cognitive development and poor management of the child's illness (Streisand, Braniecki, Tercyak, & Kazak, 2001). McCarthy, McNeil, Drew, and colleagues (2016) found that nearly half of their sample of young people and their parents (48% and 42% respectively) scored above the clinical cut-off for post-traumatic stress symptoms (PTSS) following a cancer diagnosis. Nearly one third (31% adolescents, 28% of parents) reported moderate-to-severe elevated symptoms of anxiety and depression. They also found that living outside the metropolitan area was associated wih increased levels of distress.

Following diagnosis, children receive inpatient treatment which often means a lengthy hospital stay. Research has suggested that when children are frightened, tired or in pain they rely on a stable home environment and the emotional support of their families (Angström-Brännström, Norberg, & Jansson, 2008). Being in a hospital requires patients and their families to hand over control to medical staff and place faith in treatments, which can cause a great deal of anxiety (Paul & Rattrey, 2008; Rokach & Matalon, 2007). Emotional problems can continue throughout treatment, often becoming more entrenched without adequate early intervention, such as the development of separation anxiety from parents. In addition, carers may change parenting style and how they manage their child's behaviour due to feelings of guilt, pity or as a result of the complexity of parenting while a long-stay inpatient. This can then inadvertently reinforces patterns of challenging behaviour and can lead to secondary problems in parent-child relationships and social interactions (Grootenhuis et al. 2004).

Previous research has highlighted distinctive transition periods for children and families during cancer treatment; from pre-cancer diagnosis to post-completion of the

treatment programme with the child in the maintenance phase (Woodgate and Degner, 2004). Rather than the maintenance phase being a more positive period, it was associated with a dip in psychological wellbeing and physical and mental tiredness. During this time, children still receive monthly chemotherapy at their local hospital or at home (for 2 years for girls, 3 years for boys). Returning to school can be difficult for these young people as they may be experiencing social, cognitive and physical impairment at this time (Paré-Blagoev, Ruble, Bryant and Jacobson, 2019) This period was seen as particularly challenging, as families had held on to a belief that symptoms would cease after treatment was completed. They reported that their lives were on hold and that the symptoms were a constant reminder that life is not normal. Importantly, they found that families felt isolated and that they didn't fit into the cancer world or the general world (Woodgate & Degner, 2004).

For families trying to return to a sense of normal life, an additional burden may be the physical journey that they have taken if they are from remote and rural communities. For these families, the transition also includes a physical shift back to their home environment. The National Institute for Health and Care Excellence (NICE) has highlighted areas of concern for these families, such as increased costs due to travel, work-related difficulties, living away from home and increased family stress (NICE, 2005). The National Cancer Institute (2017) has identified the inequalities of provision for those in rural areas to be an understudied area of research. Previous qualitative research has examined the whole family experience and has highlighted key themes relating to the distance from the cancer centre. These included 'dealing with distance', changes in roles, and financial (Walling, Fiala, Connolly, Drevenak, and Gehler, 2019), emotional and physical sacrifice by all members (Scott-Findlay and Chalmers, 2001). In this rural context parents became 'experts and gatekeepers', attempting to develop trust with healthcare professionals and maintain communication (Walling et al., 2019).

Children and young people and their families who live in the Highlands are required to travel around 100-200 miles to Glasgow and Aberdeen to receive treatment. Previous research has highlighted that this is likely to have a significant impact on school attendance, social functioning, family functioning (Pinquart, 2018) and create challenges related to the transition of care between local and specialist centres and teams (Walling et al., 2019).

Aims

There is insufficient research into the transition period following hospital treatment for rural families. The present study aims to explore the experience of young people and their families during this period, examining the impact on their quality of life and how they adjust to this change. The research aims to look at how this transition affects family relationships,

examining what worked well in supporting families and what may have exacerbated difficulties.

Plan of Investigation

Participants Inclusion and Exclusion Criteria

Inclusion criteria:

- Adolescents (defined as aged 10-19 by World Health Organisation , WHO) with a cancer diagnosis and their primary caregiver (parent or carer);
- Completed acute phase of treatment and either in maintenance period of treatment or completed maintenance within the last 12 months;
- Fluent in English, and;
- Consent to participate.

Exclusion criteria:

- Lack of capacity to give consent;
- Not physically well enough to participate, judged by clinical team and family;
- Acute psychological distress and/or it is judged by the clinical team that participation would cause additional burden or stress, and;
- Communication difficulties which prevent engagement in an interview.

Recruitment Procedures

The Oncology team will be asked to provide a research information sheet to families who are eligible to participate. There will a parent version and an age-appropriate version for adolescents. These will either be posted out to families or given during routine clinic appointments during the recruitment period (approximately October 2019- May 2020). Oncology staff will provide information on the researcher's role and the purpose of the study and seek verbal consent for the researcher to contact them if they are interested. The researcher will then contact those who are interested by phone to discuss the study and a suitable time and venue will be agreed for the interview for those willing to participate. Written consent will be gained at this meeting, prior to the interview, and assent will be gained gained from under 16s (Medical Research Council and NHS Health Research Authority, 2019). Also, posters advertising the study may be placed in the waiting area of the outpatient department and interested participants can contact the researcher directly.

Measures

This study will use separate semi-structured interviews of adolescents and their primary caregiver. These will last approximately an hour. A semi-structured interview schedule will be developed following discussion with key stakeholders (Oncology staff, families, academic and field supervisors). This interview schedule will be used flexibly with prompts to elaborate on important points of relevance to the project aims as necessary.

Design

The study will be qualitative, multi-perspective and retrospective in order to explore individual experiences (Smith, 2008) of the transition period. It will use Dyadic data collection and analysis which will allow the study to focus on the shared experience and the impact of cancer treatment on the relationship (Eisikovits & Koren, 2010). Multi-perspective data collection is a flexible approach, which allows researchers to observe how family members communicate about their experiences (Scott-Findlay & Chalmers, 2001).

Research Procedures

Separate interviews will be carried out with the young person and their parent/carer. The interview schedule will be used flexibly as a guide to initiate discussion and explore topics related to the aims of the study. Interviews will be recorded and transcribed, with identifying information anonymised before analysis.

Data Analysis

Data will be analysed using a Framework Approach (Ritchie and Lewis, 2003), incorporating dyadic analysis, to allow the researcher to compare narratives within and across dyads (Eisikovits & Koren, 2010). Framework analysis will provide a systematic approach, allowing amendment to the framework in order to ground the analysis in the participants' accounts (White and Newman, 2016). Framework analysis was chosen as the focus of the study is experiential (Parkinson, Eatough, Holmes, Stapley and Midgley, 2016); with an aim to examine the experience of the transition from the viewpoint of young people and their primary caregivers, how each part of the dyad understands this time and the personal significance for them.

Justification of sample size

Participants for this study will be purposefully selected on the basis that they can provide diverse detail and depth to the study (Tong et al., 2007). Previous studies with similar methodology have used 5-10 dyads (Scott-Findlay and Chalmers, 2001; White and Newman, 2016, Akeson, Worth and Sheikh, 2007; Cup et al., 2007). It is expected that this study's sample size will fall within this range and recruitment will cease when rich data relevant to the aims is collected. This is known as the concept of 'sufficiency' (White and Newman, 2016).

Settings and Equipment

Participants will be interviewed within a private room at Raigmore Hospital or the Phoenix Centre where the Paediatric Psychology team is based. Home visits will be avoided unless participants are unable to travel and it is felt that excluding them may lead to sampling bias. The researcher will consult the clinical team on any risk associated with a home visit. Interviews will be recorded on a digital voice recorder and stored on a password protected laptop.

Health and Safety Issues

Joint interviews will be carried out with young people and their parent/carer during working hours following safe/lone working practices. A Health and Safety for Researchers form is included (Appendix 1.1), which details the measures which will be taken to minimise potential risks to the participants and researcher.

Ethical Issues

The study will be sponsored by NHS Highland. Ethical approval for the study will be gained from the North of Scotland Research Ethics Committee and the NHS Highland Research and Development department. Participants will be provided with an information sheet and consent form and give verbal and written consent prior to study participation. There will be two versions of these forms, one that is accessible for adolescents and one for parents/carers. Confidentiality and participant rights to cease the interview/withdraw from the study at any time will be discussed and all participants will be provided with contact details for follow-up emotional support if required. It will be explained to participants that data will be anonymised and that participation in the study will not impact their medical care in any way. Identifiers will be removed from the data and data will be treated in accordance with General Data Protection Regulation (GDPR, 2018).

There is a potential that the interview may be emotive due to the sensitive nature of the topic and vulnerability of this population. The interview will be conducted by a Trainee Clinical Psychologist with experience in managing psychological distress, who will be working under the supervision of a qualified Clinical Psychologist who will be available to provide additional support if necessary. Any information given that highlights risk to the young person or another person will be reported to the relevant agencies and participants will be made aware of this possibility and the limit to confidentiality prior to participating.

Financial Issues

A digital voice recorder to be borrowed from the University of Glasgow. Cost form is included in appendix 1.2.

Timetable

September 2018 – Outline
January 2019 – Proposal draft
February 2019 – Full proposal submitted
July 2019 - Amended Proposal submitted
July – September 2019 - Ethics application
October 2019 – Begin recruitment
January – May 2020 - Transcription and Analysis
May – July 2020 – Write up
July 2020 – Submission of thesis
September 2020 – Viva

Practical Applications

This project is interested in the experience of young people and their parents/carers from remote and rural areas who have undergone cancer treatment. The project will explore how families cope, what they have found helpful and unhelpful, in order to improve systemic healthcare practice. The study will provide insight into the transition period towards maintenance for families and post-treatment transitions in general. This will be helpful for clinical teams working with young people with cancer and their families including those living in remote and rural locations.

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